State of Washington

Department of Social and Health Services
Mental Health Division

2005 External Quality Review
Statewide Technical Report for Prepaid Inpatient Health Plans

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June 2006

APS Healthcare

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I. EXECUTIVE SUMMARY

BACKGROUND

The state of Washington's Mental Health Division (MHD) is charged with the responsibility to evaluate the quality of mental health services provided to beneficiaries enrolled in the Medicaid managed mental health care program. Federal regulations issued by the Centers for Medicare and Medicaid Services (CMS) require that states engage an independent external quality review organization (EQRO) to review their respective public sector mental health systems and present an annual report on findings to their respective mental health departments. Details of this requirement may be found in the federal Balanced Budget Act of 1997 (BBA).

This report presents the second year findings of the Washington EQRO (WAEQRO). The period reviewed included the State's fiscal year 2005 (July 2004-June 2005) plus an additional 2 months, through August 2005.

Because the State contract changed in September 2005, and will change again in September 2006, information gleaned from the 2005 review has been combined with 2004 results to present a "snapshot" picture that can serve as a baseline for implementing changes and measuring results with the new 2006 contracts.

PROCESS

For each of Washington's 14 Prepaid Inpatient Health Plan (PIHPs), APS completed a Subpart Review, Performance Improvement Project (PIP) Validation, Performance Measure (PM) Validation, and an Encounter Validation. A report was provided to each PIHP and to the Mental Health Division upon completion of a review and feedback process. In conducting the reviews, APS followed the guidelines set forth in the Centers for Medicare and Medicaid Services protocols for each review activity, with some modifications defined by the Mental Health Division. Scoring and measurement methodologies were designed by MHD and APS, and methods for data collection, review, scoring, and analysis were the same for all PIHPs.

Due to legislation requiring, and the timing of a requalification of the PIHPs (RFQ responses were being prepared during the late fall, with a due date of December 1, 2005), the review was conducted in two phases: an initial desk review, between September and December 2005, of policies, procedures, and PIPs provided by the PIHPs, and of demographic and encounter data provided by MHD and the PIHPs. The desk review was followed by site visits to all PIHPs and two network providers contracted with each. PIHPs were provided an opportunity to review a draft report, discuss the results, and request changes before a final report was issued.

It is important to note that, based on the timing of the review, much of the material reviewed for the 2005 EQR was outdated by the time the WAEQRO completed the review process. During the summer and fall of 2005 the PIHPs had been making significant changes to their systems in order to succeed in the requalification; however, most of those changes were not captured for

this review period. In addition, the State contract with the PIHPs was revised in September 2005 to reflect recommendations from the 2004 EQR. **Due to these circumstances, many of the recommendations included in this and in the individual PIHP reports have already been addressed**.

APS Healthcare staff and consultants participating in the 2005 review and report development included:

- Harriet Markell, MA: Washington External Quality Review Executive Director
- Brad Babayan: Systems Analyst
- Marty Driggs, MA, LMHC: Administrative/Clinical Reviewer
- James Andrianos, MBA: Data Analysis Consultant
- Stephan Magcosta: Editor

RESULTS

This report provides results from the four review activities conducted by the WAEQRO for each of the 14 PIHPs in the state of Washington. The data is analyzed for all PIHPs, providing individual PIHP and statewide results; included is an assessment of strengths and necessary improvements related to the quality of mental health services provided to Medicaid enrollees. Detailed information can be found in the reports compiled for each PIHP and provided to MHD.

Subparts

For each PIHP, APS reviewed all BBA Subpart elements that did not achieve at least a minimal "Expected" score of 3 in 2004. The 2005 scores reflect those results plus the 2004 scores that were not reviewed in 2005. Scores were based on a 6-point scale (0-5) for most elements.

Subpart C – Enrollee Rights and Protections

Subpart C includes elements addressing such requirements as client understanding of their rights, incorporation of advance directives in the treatment process, and availability of written information. There was noticeable statewide improvement over 2004 with respect to PIHPs meeting the requirements of this subpart. At the end of the 2004 review, 49% of Subpart C scores were at or above Expected level of performance. After the 2005 review, 80% of the items meet that level, reflecting a 31% improvement from 2004. Twenty percent of the items in Subpart C remain below the Expected level.

Based on the scoring guidelines, results indicate that, by and large, PIHPs have relevant policies and procedures in place, and PIHP and Provider Network staff have received formal or informal training on enrollee rights and protections. Two factors contributed to elements scored below the Expected level. First, policies and procedures were underdeveloped and/or missing key requirements. Second, key PIHP and Network Provider personnel need training to increase knowledge and improve application of relevant policies and procedures.

Subpart D – Quality Assessment and Performance Improvement

Subpart D addresses a wide variety of requirements related to service access, network availability, cultural accommodations, authorization processes, and quality of care. At the end of the 2004 review, 47% of Subpart D scores were at or above the Expected level of performance. After the 2005 review, 63% meet that level, reflecting a 16% improvement from 2004. A full 37% of the items in Subpart D remain below the Expected level, and no PIHPs have achieved all scores at or above Expected. In addition, more than 40% of Subpart D scores are below Expected for 8 PIHPs. Subpart D presents the most difficult set of requirements for the PIHPs.

Subpart F – Grievance System

This Subpart includes requirements regarding administration of the grievance and appeal system as well as supports and protections for consumers as they engage with that system. PIHPs have improved statewide in meeting the requirements of this Subpart. At the end of the 2004 review, 40% of Subpart F scores were at or above the Expected level of performance. After the 2005 review, 74% of the items meet that level, reflecting a 34% improvement from 2004. Twenty-six percent of items in Subpart F remain below the Expected level. Evidence of the work quality in this area includes one PIHP that scored at or above Expected on all Subpart F items; also, more than half of the 14 PIHPs have less than 20% of scores below Expected, and none scored at zero (0).

Subpart H – Certifications and Program Integrity

Subpart H sets forth requirements associated with prevention of fraud and abuse and compliance with privacy laws. A comparison of 2004 and 2005 reveals a 12% improvement. At the end of 2004, 75% of Subpart H scores were at or above the Expected level of performance. After the 2005 review, 87% of items meet that level, with 13% remaining below. This subpart is scored differently than the others, using a pass/fail system – statewide performance on these critical issues is excellent.

Performance Improvement Projects

While positive movement across the mental health system was evidenced in the many clinical study topics with great potential, APS found that most PIHPs continued to have minimal understanding of CMS PIP protocols and process. With some notable exceptions, plans were brief, incomplete, and lacked necessary detail. More often than not, documentation submitted failed to provide evidence that PIHPs had worked within a committee context to develop and implement their plans. With improved structure and data analysis, these projects could provide important improvements in the care provided to consumers.

In addition, all PIHPs were receptive to the technical assistance provided during the site visits, and most are requesting a statewide training; since the individual reports were completed, additional requests for technical assistance regarding PIP development have been received by the EQRO. APS expects that further training in this area and continued technical assistance will yield increasingly positive results in future reviews.

Because the majority of PIPs reviewed did not meet expectations for most steps of the

validation process, APS has chosen to report a summary of strengths and difficulties of the 2005 PIPs, found in the body of this report. Detailed information for each PIHP's PIPs can be found in their individual reports, attached.

Performance Measure Validation

As part of validating the Performance Measures, APS reviewed basic system capabilities for each PIHP, updating information gathered in 2004. The extent to which PIHP information systems capture, store, transmit, and secure data is a strong reliability indicator of data submitted for the above measures, as well as for many others.

The WAEQRO also investigated system capabilities and changes in the State's performance measure calculation system. The Mental Health Division has contracted with an external entity for calculation of the measures. The code used by this entity is the same as that evaluated in last year's review; it was found to be sound at that time, and there is no reason to alter that finding. Another advantage of this new arrangement is that the disaster recovery model now in place protects this data and its related calculations.

In another change, data sets for calculating measures are now frozen and archived rather than using dynamic data sets that preclude replicating the results.

In the state of Washington, Performance Measures evaluated by the WAEQRO are State-defined. These measures and findings are as follows.

- **Medicaid Penetration rates** – for community outpatient services by age group.

  Finding: Substantially Compliant

  Issues concerning this measure remain largely unchanged from last year. Accuracy of the denominator continues to come into question. Use of the unduplicated member year is far less granular than other types of member month calculation.

  Significant progress was found in the overall system controls used to ensure accuracy and completeness of data. A number of PIHPs implemented fairly comprehensive audits similar to those used by WAEQRO in the Encounter Validation.

- **Medicaid Utilization rates** – for community outpatient services by age group.

  Finding: Not Valid

  This year's Encounter Validation result is the primary reason this item remains scored as Not Valid. Last year, 9% missing seemed large; this year, at 16.85%, close to double that number is missing. There is a direct relationship between this measure and those missing encounters. Until the systems performance level increases in the area of data collection, it will be hard not to see an impact on the validity of values reported in this measure. Further detail on this topic may be found in the Encounter Validation section of this report.

- **Consumer Survey Results** – from the Mental Health Statistics Improvement Program (MHSIP) Youth and Family Services Surveys.

Findings: Valid

There were no changes to this system since the last review. The survey methodology employed is sound and the sampling used is valid. The most problematic area of the surveys is sampling. Techniques are being explored and over-sampling by request continues.

Encounter Validation

Conducting an Encounter Validation is new to this year's review and involved three complementary sets of activities:

1. Review of the State's dataset for accuracy and completeness.

2. Comparison of select data fields in the State's MIS against the clinical record to ensure that all data submitted by the providers is accurate, complete, and has supporting documentation; and

3. Comparison of the clinical record against the State's data to ensure that all required data was submitted.

To accomplish these activities, a simple random sample of encounters was drawn from qualified clients (those with at least one Medicaid service during the defined period of the review). To determine an adequate sample size, the 'Sample Size Calculator' found on The Survey System web site was used (www.surveysystem.com/sscalc.htm). For fiscal year 2005, there were 3,024,038 Medicaid encounters. The calculator determined that a sample size of 411 encounters would ensure a confidence level of 95% and a confidence interval of +/- 5 points, enabling the WAEQRO to draw valid conclusions about the accuracy, timeliness, and completeness of the data. A draw of 30 client records from each PIHP was calculated to yield at least 411 encounters from each.

Findings

Phase 1: In evaluating the State dataset, thirty-one of 34 data elements examined for completeness and accuracy were found to be compliant with the standards. While this result appears reasonable, issues emerged which called close to 1/3 of those compliant scores into question. These concerns include data structure, data dictionary definitions, and physical record structure, all of which are discussed in the body of this report.

Phase 2: Two comprehensive sets of data were studied independently (the A-Side and the B-Side) to capture data validity in two directions: ensuring that data in the State's data set is documented fully in the clinical record, and that data in the clinical record is submitted reliably to the State. Results in both directions should have been quite similar (within 5 points); however, they were not. There was an 11.36% difference between the two sets in the encounter matches.

2005 RECOMMENDATIONS

The findings of the 2005 External Quality Review revealed significant overall improvement compared to 2004. Progress in the areas of Enrollee Rights and Grievance and Appeal systems is evident in all analyses. In addition, PIHPs utilized feedback from the 2004 review in prioritizing their quality improvement activities; indeed, many mentioned that information provided last year was quite helpful

Recommendations from the 2005 review, while again likely outdated due to timing, were based on the most problematic areas.

Subparts

- Develop a process to officially adopt policies and procedures
- Ensure that policies and procedures are complete and current and implemented accurately and effectively at the provider level; prioritize staff training
- Provide regular and thorough oversight of sub-delegated activities
- Address deficiencies in selection and implementation of practice guidelines

Performance Improvement Projects

- Use available data to identify possible improvement needs
- Formulate study questions to reflect investigation of the impact of specific interventions, including a specifically-defined set of indicators
- Create and implement a reliable data analysis plan;
- Design and implement reliable sampling strategies;

Performance Measures

At the end of the review period, the EQRO remained concerned about some key processes, including, but not limited to, data entry structures and rules that mask true values. In addition, few PIHPs calculate member months, and variance in Member ID assignment procedures is clearly evident. Specific recommendations include the following.

- PIHPs and the State are again encouraged to pursue calculating member months. Per member per month (PMPM) measures are commonly used in the managed healthcare industry, and member month data allows for more accurate utilization and penetration rate calculation.

- Document, in policy, the requirement for encounters easily under-reported. This policy should include a process or procedure to ensure that encounter data is not lost due to unique circumstances.

- The State is encouraged to design a reporting process that ensures reproducible performance measure calculations. To enable this functionality, processes and procedures must be sufficiently documented so as to allow another entity to successfully reproduce the results without any other form of guidance. In addition,

the *methods* employed to extract data used in calculating the performance measures need to be defined and reproducible. While the WAEQRO recognizes that these issues are being addressed, it is critical to keep the recommendation current until it is completed.

- The EQRO recommends that the State and the PIHPs consider a standard for maintaining a detailed, secure, and sharable provider database and for collecting and regularly updating data such as site locations, number, type, and location of practitioners, and credentialing information. Strategic and creative planning and problem solving regarding local, regional, and statewide access would be greatly enhanced with this type of database.

Encounter Validation

- The WAEQRO recommends that the encounter validation process be conducted on an ongoing basis to ensure consistency of the process and minimize potential for anomalous situations to impact the result.

In addition, many of the problems identified in Encounter Validation understandably impact the findings of the Performance Measure analysis. Attention to key processes and structures that reduce reliability of the data would greatly enhance the State's ability to manage its environment.

II. INTRODUCTION

The state of Washington's Mental Health Division (MHD) is charged with responsibility to evaluate the quality of specialty mental health services provided to beneficiaries enrolled in the Medicaid-managed mental health care program. This report presents the second year findings of an external quality review of all Prepaid Inpatient Health Plans (PIHPs), conducted by a division of APS Healthcare: the Washington External Quality Review Organization (WAEQRO). The period reviewed included the State's fiscal year 2005 (July 2004-June 2005) plus an additional 2 months, through August 2005.

BACKGROUND

State of Washington Mental Health System

The Mental Health Division in the state of Washington is one of the divisions in the Health and Recovery Service Administration (HRSA) of the Department of Social and Health Services (DSHS). The Division has responsibility for ensuring the provision of clinically necessary mental health and mental health-related services to all Medicaid enrollees, as well as providing a set of emergency and priority services to all state citizens.

The Mental Health Division began delivering outpatient mental health services under a 1915(b) waiver in 1993. The capitated, managed mental health system gave the county or multi-county based RSNs (Regional Support Networks) the ability to design an integrated system of care and, as necessary, subcontract with a network of Community Mental Health Agencies (CMHAs) capable of providing high quality, required mental health services. Services covered under the waiver were the full range of community mental health rehabilitation services offered under the Medicaid State Plan through a fee-for-service (FFS) reimbursement system. In 1997, an amendment to the existing waiver was approved which incorporated community psychiatric inpatient services for Medicaid-eligible adults, older persons, and children into the capitated contracts with the RSNs. The entities within the RSNs responsible for the managed care portion of the mental health delivery system are now called PIHPs.

Each RSN is responsible for ensuring that everyone eligible for services in their area receives the mental health care they need. In addition, each must make emergency services available to all.

Demographics

The state of Washington is varied geographically, economically, and ethnically. According to the U.S. Census, as of 2005, Washington has an estimated population of 6,287,759. The highest percentage of the state's population resides on the west side of the Cascade mountain range, which runs the entire length of the state, creating a one third/two thirds divide. The most heavily populated urban center is greater Seattle. Most of the remaining urban population resides in smaller cities along the I-5 corridor from Vancouver, at the southern boundary of the state, up to the southern edge of Seattle. One exception is Spokane, which is on the east side of the mountains and boasts a population of about 500,000.

Major state industries include the development and distribution of information technology, located primarily in Seattle; agriculture, most of which lies in the rural two-thirds of the state east of the Cascades; the design and manufacture of jet aircraft; lumber and wood products industries; hydroelectric power generation; and tourism. Though the state economy has been steadily recovering from the burst dot-com bubble in 2001, the Medicaid population continues to grow. Numbers enrolled in Medicaid and served by the mental health system in 2004 are shown below.*

Figure 1: Medicaid Enrollment and Penetration

	Medicaid Enrollees	Number Served	Penetration Rate
Northeast	19,433	1,202	6.2%
Grays Harbor	17,621	1,823	10.3%
Timberlands	22,477	2,641	11.7%
Southwest	22,670	2,940	13.0%
Chelan-Douglas	22,441	1,714	7.6%
North Central	41,119	2,140	5.2%
Thurston-Mason	45,292	3,762	8.3%
Clark County	69,358	5,399	7.8%
Peninsula	50,601	4,075	9.4%
Spokane County	93,142	8,096	8.7%
Greater Columbia	158,039	12,022	7.6%
Pierce County	130,213	9,020	6.9%
North Sound	156,815	13,148	8.4%
King County	231,539	26,086	11.3%
Statewide	1,080,760	92,999	8.6%

*Based on 2004 numbers published in the Performance Indicator Report, reflecting enrollment during the review period.

2005 REVIEW OBJECTIVES

History

Washington State Mental Health Division awarded its first EQRO contract to APS Healthcare in April 2004. The first review year spanned July 2004 through June 2005. During that review, conducted between August 2004 and March 2005, APS reviewed all Balanced Budget Act (BBA) Standards, performed an Information Systems Capability Assessment (ISCA) review for all PIHPs, and validated a set of performance measures calculated and specified by the State. The individual and statewide final reports contained recommendations intended for review during the next review cycle. In addition, MHD issued corrective actions based on requirements that staff felt to be the most essential for public sector, managed care organizations.

Purpose of the 2005 Review

The EQR process is based, in part, on a continuous quality improvement model. Using results of the 2004 EQR review as a baseline, the State wanted to first focus on PIHPs meeting a minimum acceptable level of performance across the BBA requirements. From that point, the EQR evaluates ongoing performance, with a goal over time of seeing all PIHPs make steady improvement in key areas defined either by the State, or through their own analyses.

Based on the 2004 findings, the 2005 review was designed to:

- Review and measure improvement in operational and clinical practices that last year were found to be below minimal acceptable levels;
- Evaluate the status of performance improvement projects (PIPs);
- Update information regarding PIHP Information System (IS) capabilities and functionality;
- Validate performance measures specified by the State; and
- Conduct an encounter validation.

Because the State contract changed in September 2005, and will change again in September 2006, information gleaned from the 2005 review has been combined with 2004 to present a "snapshot" picture that can serve as a baseline for implementing changes and measuring results with the new 2006 contracts.

2005 REVIEW ACTIVITIES

For each of the 14 PIHPs, APS completed a Subpart Review, Performance Improvement Project Validation, Performance Measure Validation, and an Encounter Validation. Upon completion of the review and feedback process, a report was provided to each PIHP and to the Mental Health Division. In conducting the reviews, APS followed the guidelines set forth in the Centers for Medicare and Medicaid Services protocols for each review activity, with some modifications defined by the Mental Health Division. The methods for data collection, review, scoring, and analysis were the same for all PIHPs and are described below.

The 2005 review was conducted in two phases: an initial desk review of policies, procedures, and PIPs provided by the PIHPs, and of demographic and encounter data provided by MHD and the PIHPs, followed by site visits to all PIHPs and to two network providers contracted with each. The following table outlines activities involved in this year's review, including a description of the reporting and feedback process. Samples of all relevant communication materials are included in the appendices.

Figure 2: 2005 EQRO Activities

Activity	Timeline	Documents/Content
Pre-onsite		
1. Communication re: 2005 review	July 21, 2005 to all PIHP Administrators and MHD	Email and memo with general information about 2005 review
2. Subpart materials request and review	July 21, 2005 to all PIHP Administrators and MHD; due to APS August 9.	Memo and instructions re: document submission; scoring tools
3. Questions and Answers	Between August 4 and August 16 to all PIHP Administrators and MHD	Series of emails/memos responding to questions re: subpart material submission
4. Due date extension	September 2 to PIHP administrators	Email extending deadline for subpart document submission to August 19
5. PIP materials request and review	September 12 to all administrators and MHD; due to APS on September 30	Email and memo describing PIP review and instructions for submitting materials; sample review tool; suggested guidelines
6. Encounter Validation data/materials request	September 15 October 27 to all PIHP Administrators and MHD	Data received from MHD; Email and memo with detailed information re: the process and instructions for required records; mailing instructions; certificate of authenticity to be signed
7. Communication of site visit schedule and agendas; orientation call with Executive Director	One month prior to scheduled site visit for each PIHP	Email/agenda with names of network providers to be visited and instructions for orientation call
8. Site visit orientation call	With each PIPH administrator, 2 weeks prior to visit	Review logistics, answer questions, discuss agenda
Onsite Review		
1. PIHP visit	Between December 1, 2005 and April 26, 2006	Three hours interviewing management team re: changes, specific questions about subparts, review PIPs, update IS information

Activity	Timeline	Documents/Content
2. Network provider visit	Between December 1, 2005 and April 26, 2006	1.5 hours with each of 2 providers for each PIHP; interviewing management and direct service staff re: PIHP oversight and requirements
Post Onsite		
1. Subpart scoring	Finalized during 30 days after site visit	Subpart Scoring Tool
2. PIP evaluation	Finalized during 30 days after site visit	PIP Evaluation Tool
3. Draft report	Thirty days after site visit to each PIHP administrator	Instructions for submitting feedback about results/score change requests
4. Debrief conference calls	Five days after draft submitted to PIHP; with administrator and staff	Review results; highlight strengths and recommendations for improvement; answer questions; consider subpart scores questioned
5. Final draft report		
6. Encounter validation		
7. Performance measure validation	April 24th and 26th , 2006 interview with MHD contractors	Review of PM-related processes, e.g. data capture and calculation methodologies; survey methods
8. Final Draft PIHP reports	To each PIHP and MHD 3 days after debrief conference calls	Completed report except for encounter and performance measure validation results
9. Draft Statewide report	To MHD May 18, 2006	
10. Final Statewide report/Final PIHP reports	Statewide report to MHD, CMS June 9, 2006; PIHP final reports to each PIHP June 9, 2006	Includes encounter and performance measure validation results

CONTENT AND ORGANIZATION OF THE REPORT

This report provides:

1. An overview of 2004 results, as baseline for 2005 performance and analysis;
2. A description of how data from these activities were aggregated and analyzed, and conclusions drawn as to the quality, timeliness, and access to care furnished by the PIHPs.
3. A summary of the findings from the EQR activities for all PIHPs;
4. An assessment of PIHP and statewide strengths and weaknesses with respect to provision of health care services furnished to Medicaid recipients;
5. Recommendations for improving the quality of health care services provided by the PIHPs.

This report meets the federal requirement for the preparation of an annual EQR report, as set forth in the Balanced Budget Act (BBA) of 1997 42 CFR 438.364.

The sections are organized by review topic (Subparts, Performance Improvement Projects, Performance Measures, and Encounter Validation) and are presented visually, as well as in narrative. Each section provides information about individual PIHP performance and change over time, comparisons statewide, and system-wide observations and recommendations for quality improvements. Progress on 2004 WAEQRO recommendations is also included in each topic area. The final summary provides a recap of conclusions and recommendations.

PROFILE OF REVIEWERS

Harriet Markell, MA: Washington External Quality Review Executive Director
Harriet is responsible for the overall operation of the Washington EQRO and is the primary point of contact for the Mental Health Division and the PIHPs. She reviews PIHP Performance Improvement Projects, assists with evaluation of the Subparts, and oversees data analysis processes. Harriet has a varied background in direct clinical care, program development and management, managed behavioral healthcare operations, and non-profit social service operations.

Brad Babayan: Systems Analyst
Brad is a senior computer systems analyst for APS Healthcare's WAEQRO. As a member of the WAEQRO team, Brad evaluates system capabilities of the PIHPs and the Mental Health Division, and also validates the system of performance measures used for quality and performance improvement efforts. Brad also serves on the APS corporate HIPAA implementation team. Brad has twenty-five (25) years of varied experience working in the information technology field. He began programming while in the military and has since gained experience in hardware, networking, and enterprise management.

Marty Driggs, MA, LMHC: Administrative/Clinical Reviewer
As the Administrative/Clinical Reviewer for the Washington EQRO, Marty holds primary responsibility for evaluating PIHP compliance with BBA standards. Marty has worked in the state of Washington's mental health system for over 25 years in various capacities, including the provision of direct care, clinical supervision program management, and as an RSN

Administrator. In addition, Marty has a private consulting business that includes (in part) development of policies and procedures related to management and direct service functions, facilitation of stakeholder forums, mediation and conflict resolution, and facilitation of contract negotiations.

James Andrianos, MBA: Data Analysis Consultant
Jim has assisted the WAEQRO with evaluating the results of the subpart reviews and developing methods for presenting and discussing PIHP performance, both individually and as comparisons. Jim has an extensive background in measurement and evaluation of clinical quality and efficiency from claim repositories, financial modeling, cost accounting and rate-setting for healthcare and social services, and design and implementation of management reporting systems.

USE OF THIS REPORT

Because the EQRO understands that there will be multiple types of stakeholders reviewing this report, the following roadmap identifies those parts that may be most useful for each.

Figure 3: Report Use Guide

Stakeholder Group	Report Section(s)
State agency (MHD/DSHS) and PIHPs	• Entire report
CMS	• Entire report, including Appendices
Consumers, advocacy groups, advisory boards	• Introduction • Executive Summary • Final Summary
PIHP Governing Boards	• Executive Summary • Subpart Summary • Encounter Validation and Performance Measurement Results
State legislators	• Introduction • Executive Summary • Final Summary

III. RESULTS FOR 2004 – 2005 EQRO REVIEWS

This report provides results from the four review activities conducted by the WAEQRO for each of the 14 PIHPs in the state of Washington. For each activity, the report describes the objectives, methods of data collection and analysis, description of data, and conclusions and recommendations drawn from the data. The data is analyzed for all PIHPs, providing individual PIHP and statewide results; included is an assessment of strengths and necessary improvements related to the quality of mental health services provided to Medicaid enrollees. Detailed information can be found in the reports compiled for each PIHP and provided to MHD (see, **Attachment 1 – PIHP Reports**).

SUBPART REVIEW

In conducting the 2005 Subpart reviews, the WAEQRO followed guidelines set forth in the Centers for Medicare and Medicaid Services (CMS) protocols. Methods of data collection and analysis with respect to each Subpart were uniformly applied to each PIHP. Common elements involved the use of a standardized data collection monitoring tool developed by the Washington State Mental Health Division (MHD), extensive document review and analysis, standardized scoring methodology, and onsite reviews that included interviews with PIHP staff and members of their Provider Networks.

Each of the 14 Subpart reviews was conducted in two phases: a desk review of documents prepared and submitted by the PIHPs for the review period July 2004 through August 2005, followed by a site visit and interviews with each PIHP and two subcontracted Network Providers selected by the WAEQRO. The interview questions and sequence reflected the content and order of the Subparts; following this sequence complied with CMS protocols with respect to conducting reviews in a logical fashion that assist in identifying each PIHP's overall performance and compliance with Federal and State regulations. The Subparts addressed in the reviews included the following.

- Subpart C-Enrollee Rights and Protections
- Subpart D-Quality Assessment and Performance Improvement
    - Access Standards
    - Structure and Operation Standards
    - Measurement and Improvement Standards
- Subpart F-Grievance System
- Subpart H-Certifications and Program Integrity

The desk reviews provided an opportunity for the WAEQRO to make an initial determination of progress on the part of each PIHP with respect to meeting required Federal and State regulations and standards. The PIHP interviews included Administrators and other key staff responsible for quality, care, and utilization management functions. Interviewees were asked to provide an overview of changes in their organization, Provider Network, and overall system of care since the last review. This overview included focused updates on critical areas of operation (Sub-delegation, Quality Management, Access/Network Capacity, Utilization Management,

Grievance System, Information System, and Practice Guidelines). In addition, staff at each PIHP responded to a series of questions designed to enhance the WAEQRO's understanding of documentation and responses to specific elements from the Subpart protocols (see, **Attachment 2 – Sample Site Visit Agenda**).

The onsite interviews with Network Providers began with an observation of posted accessible client rights and grievance information. Interviews were then conducted with two separate groups: key management personnel, followed by more extensive interviews with direct service staff. This process allowed the WAEQRO an opportunity to assess the degree to which the PIHPs' operational standards and contract requirements are integrated throughout their Provider Networks and regional systems of care. In addition, the WAEQRO was able to explore how the PIHPs' ongoing quality improvements were directly and/or indirectly impacting the quality of care provided.

Subparts Scoring

A comprehensive, MHD-designed, External Quality Review (EQR) compliance review tool and set of scoring guidelines were adapted from the CMS protocols for the 2004 review. With the exception of modifications described below, the same review tool and scoring guidelines were utilized during the 2005 Subpart review (see, **Attachment 3 – Subpart Review Tool, Attachment 4 – Scoring Guides**). Tool and scoring guidelines were designed to identify each PIHP's degree of compliance with the Balanced Budget Act (BBA), and specific MHD contract requirements and priorities, as well as their strengths and areas of needed improvement.

Throughout the scoring and analysis, the concept of an Expected performance recurs. A score of Expected denotes either of the following:

- A score of 3 or better for Subparts C, D, and F
- A score of 1 for Subpart H

The External Quality Review of 2004 was the first such review to take place. It was intended to provide baseline information that MHD and individual PIHPs could use for ongoing evaluation of performance and processes directly related to BBA standards and MHD contract requirements, as well as to identify and recommend system interventions that would improve quality. To advance along this path of continuous quality improvement (CQI), MHD requested that the 2005 Subpart review focus on those elements that were scored below Expected in 2004.

Accordingly, items not reviewed in 2005 include the following.

- Elements in Subparts C, D, and F that were scored 3 and above in 2004;
- All components (with the exception of the data certification elements[1]) in Subpart H with a score equivalent[2] to 1 during the 2004 review;
- Questions 68-70 that pertain to the Information Systems Capability Assessment (ISCA), which was not conducted this year; and

[1]All Subpart H data certification elements were rescored in 2005.
[2]Subpart H used three different scoring methodologies in 2004. To use a consistent scoring methodology in 2005, scoring was simplified throughout Subpart H to a two (2) point scale, zero to one (0-1).

- All items associated with the Performance Improvement Projects (PIPs), as PIPs were scored using the CMS PIP Protocol and will be discussed in a separate section of this report.

Subparts C, D, and F were scored using the two scoring guides developed by the MHD. Scoring Guide 1 was used for scoring MHD-required policies, procedures, and contract language based on BBA requirements and provisions. Scoring Guide 2 was used for scoring BBA provisions for which MHD does not specifically require policies and procedures; the guide however, does require that specific mechanisms, processes, and/or analyses be in place. These scoring guides use a 6-point scale, zero to five (0-5), which denote the following.

0 = No Compliance (no documentation/processes);
1 = Insufficient Compliance (documentation/processes exist);
2 = Partial Compliance (documentation processes available/distributed to personnel);
3 = Moderate Compliance (personnel trained, aware of documentation/processes);
4 = Substantial Compliance (provision articulated, implemented locally);
5 = Maximum Compliance (provision thoroughly/consistently implemented).

For each PIHP, the minimum Expected performance on each element scored in Subparts C, D and F is 3.

Subpart H was scored differently in that it was based on a 2-point scale zero to one (0-1) as follows:

0 = No Compliance (insufficient evidence)
1 = Compliance (sufficient evidence exists)

An additional difference is that all four Subpart H questions pertaining to data certifications were rescored in 2005. The remaining items in Subpart H were rescored only if the PIHP had a score equivalent[3] to zero in 2004. For each PIHP, the minimum Expected performance on each element scored in Subpart H is one.

It is important to note that in 2004 three different scoring methodologies were used in Subpart H. To create a consistent scoring methodology for 2005, scoring was simplified throughout Subpart H to a two (2) point scale, zero to one (0-1). To achieve data comparability across all Subparts, scores of one (1) were then converted to three (3). In addition, all elements of Subpart H were combined into 3 scored items in 2004; in 2005 a score was applied to each individual element, resulting in a total of 12 scored items.

The following sections present a graphical and narrative review of Subpart results for all 14 PIHPs. First is a recap of the overall results and recommendations from the statewide 2004 PIHP review; this provides a baseline for the 2005 performance and results analysis. To provide a comprehensive set of scores, the 2005 Subpart results include a roll-up of 2004 scores of 3 or higher in Subparts C, D, F[4] or a score of 1 in Subpart H[5], and 2005 scores for all remaining

[3]See, footnote 2, page 15.
[4]Some exceptions apply due to changes in scoring tools, and score conversions to adequately compare scores year

items. The 2005 results exhibit statewide and PIHP-specific distribution of scores, common areas of strength and improvement, and percentage of change/improvement per PIHP. Measures of statewide improvement over time are also displayed, as are system-wide observations of strengths and recommendations for quality improvement.

to year.
[5] See, footnote 1, page15.

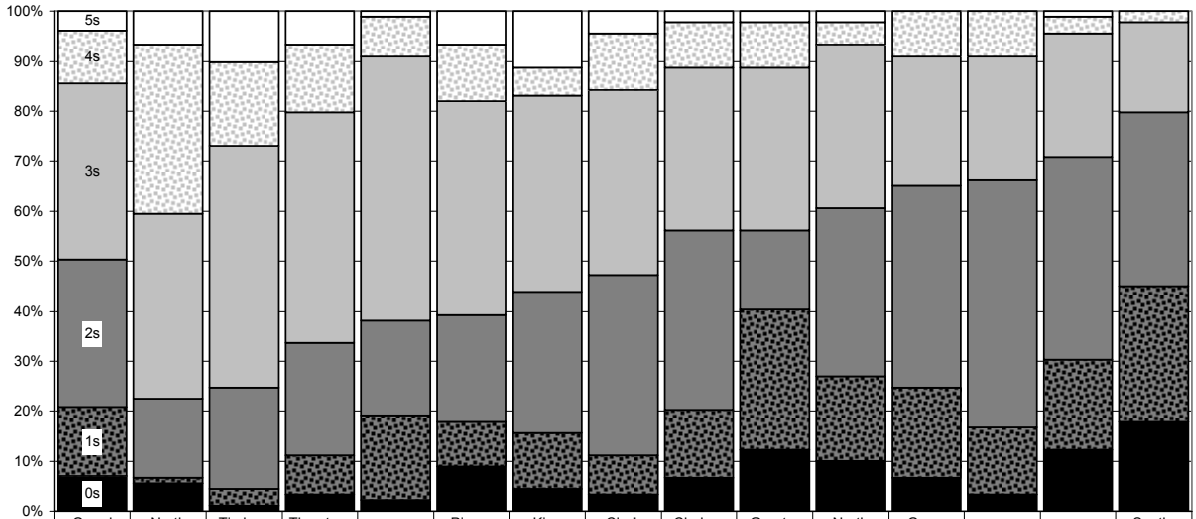
2004 Subpart Results Overview

2004 Distribution of Scores

The 2004 All Subparts Distribution of Scores by PIHP chart, below, identifies each PIHP's distribution of scores (0, 1, 2, 3, 4, or 5) for all Subparts. The total column height accounts for 100% of item responses. The PIHPs are arrayed by performance from best to worst, moving from left to right across the horizontal axis. *This ranking is based on the greatest number of scores at or above the Expected performance level (3, 4, or 5)*. Below the chart, a data table displays the actual score count for each PIHP. These numbers drive the percentages in the stacked column chart.

For statewide comparison, the first column displays scores for all 14 PIHPs, providing a statewide overall distribution. Of note is that 49.6% of all scores are at Expected and above (3, 4, and 5), and 50.3% are in the below Expected range (2, 1, and 0). Also noteworthy is that seven, or half of the PIHPs, reflect a greater number of scores in the Expected category and seven PIHPs have a greater number of scores that fall below Expected.

Figure 4: 2004 All Subparts
Distribution of Scores by PIHP



	Grand Total	North Sound	Timber-lands	Thurston-Mason	NEWRSN	Pierce County	King County	Clark County	Chelan-Douglas	Greater Columbia	North Central	Grays Harbor	Peninsula	Spokane	South-west
5s	49	6	9	6	1	6	10	4	2	2	2	0	0	1	0
4s	130	30	15	12	7	10	5	10	8	8	4	8	8	3	2
3s	440	33	43	41	47	38	35	33	29	29	29	23	22	22	16
2s	368	14	18	20	17	19	25	32	32	14	30	36	44	36	31
1s	171	1	3	7	15	8	10	7	12	25	15	16	12	16	24
0s	88	5	1	3	2	8	4	3	6	11	9	6	3	11	16

Based on the statewide overall distribution of scores and the Scoring Guidelines (see, **Attachment 4**), this chart generally indicates that for 50% of the elements scored, two issues contributed to the low scores: (1) policies and procedures were underdeveloped

and/or missing key requirements, and (2) key PIHP and Network Provider personnel need training to increase knowledge and application of related policies and procedures. The elements with the lowest scores and greatest number of PIHPs with a score below Expected were selected for recommended quality improvements in 2004.

2004 Subpart Results and Recommendations

The following recommendations describe opportunities for improvement that the WAEQRO team identified as priorities during the 2004 EQR process. The first five were identified as the highest priority, statewide systemic opportunities for improvement. The results and recommendations are tied to the Code of Federal Regulations (CFRs) to which they apply.

438.10 Information Requirements/438.206(c)(2) Culturally Competent Service Delivery

Results

A majority of PIHP policies and procedures were deficient with respect to accessible information requirements. PIHP staff reported confusion relative to client materials specifically required for translation. Staff also expressed uncertainty related to the language requirements for translated client materials. In addition, materials for enrollees who are blind, deaf, or hard of hearing were not available.

Recommendation

Incorporate information requirements into PIHP policies and procedures. Propose that the State establish a standard definition for what constitutes “client materials” and clarify translation requirements with regard to “prevalent” regional languages versus the seven languages designated by DSHS.

438.210(c) Notice of Adverse Actions/438.404 Timing of Notice

Results

All interviewed PIHP and Network Provider staff reported that denial determinations were occurring based on lack of medical necessity. Only one PIHP had started the process of issuing Notices of Action to enrollees and informing requesting providers of the denial determination. There was a pervasive lack of understanding among PIHPs and their Network Providers as to what constituted a denial and whether a PIHP or Network Provider was the appropriate entity to issue a Notice of Action.

Recommendation

The State should clarify the operational definition of a denial for inpatient and outpatient services and standardize the Notice of Action process to monitor and track denials. Recommend that PIHPs clarify the entity responsible for issuing Notice of Actions and immediately implement the requirement of issuing such notice when appropriate. Provide training to all Provider Network staff on Notice of Actions and appeals.

438.210(e) Compensation for Utilization Management Activities

Results

Utilization management (UM) practices across the State lacked clarity, consistency, and understanding with respect to the benefits of well-designed utilization management plans. Of greatest concern was a lack of implemented mechanisms for outpatient UM that protect against financial incentives tied to authorization decisions. The majority of PIHP UM structures are susceptible to managed care fraud and abuse (intentional and/or unintentional), particularly with regard to under and over utilization, when the Provider holds risk. PIHPs do not have adequate oversight procedures to detect under and over utilization.

Recommendation

State leadership and direction is recommended for defining and implementing best practice standards for managed care utilization management activities.

438.230 Subcontractual Relationships and Delegation

Results

PIHPs have not adequately conducted formal evaluations of subcontractor ability to perform PIHP-delegated functions prior to their delegation. PIHPs do not consistently monitor subcontractor performance of delegated functions, nor do written agreements with subcontractors adequately specify activities and responsibilities associated with these PIHP-delegated functions. As a result, the roles and responsibilities of PIHPs and their subcontractors are sometimes indistinguishable; at times, they conflict and create gaps in the regional system of care.

Recommendation

Before delegation, each PIHP must evaluate a prospective subcontractor's ability to perform the activities in question. Ensure that a written agreement specifies the delegated activities and responsibilities and provides for sanctions or contract revocation if subcontractor performance is inadequate. Formally monitor subcontractor performance on an annual basis, and enforce corrective actions as needed.

438.236 Practice Guidelines

Results

Officially adopting and implementing research-based practice guidelines was new to PIHPs. Many adopted practice guidelines were developed locally and not based on valid and reliable clinical evidence. Network Providers and enrollees were infrequently included in the selection and development of practice guidelines. There was minimal evidence depicting application of practice guidelines to processes of care.

Recommendation

PIHPs select practice guidelines by utilizing available research and research-based practice guidelines during the adoption process. PIHPs must clarify responsibility for developing and adopting practice guidelines and ensure that two new practice guidelines are adopted for this coming year. Include enrollees and Network Providers in the selection and development of practice guidelines. Provide formal training to PIHP and

provider staff with respect to officially adopted practice guidelines to ensure their consistent application to processes of care.

438.100(b) Specific Enrollee Rights

Results

Eleven of fourteen PIHPs scored below the "Expected" level.

Recommendation

Each PIHP must ensure that notice of the grievance system and enrollee rights in all languages required by DSHS are posted in public areas accessible to enrollees.

438.100(d) Compliance with Other Federal and State Laws

Results

Ten of fourteen PIHPs scored below "Expected".

Recommendation

Establish specific PIHP policies and procedures for monitoring subcontractor compliance with enrollee rights and other Federal and State laws.

438.106 Liability for Payment

Results

Ten (10) of fourteen (14) PIHPs scored below "Expected".

Recommendation

PIHP Network Provider contracts should include language that ensures enrollees are not charged or held liable for payment under any circumstances described in applicable law or regulation.

438.10(g) Advance Directives

Results

Ten of fourteen PIHPs scored below the "Expected" level.

Recommendation

All fourteen PIHPs must ensure that their subcontracts clearly reinforce the requirement that all adult enrollees be informed, in writing, of their right to be advised of the Mental Health Advance Directive and related policies, as evidenced in their clinical record by the enrollee-signed statement of choice.

438.206(b)(5) Delivery Network-Out of Network Providers Coordination with PIHP with Respect to Payment

Results

Twelve of fourteen PIHPs scored below "Expected".

Recommendation

Develop and implement PIHP policies regarding the use of out-of-network providers and procedures to support coordination of payment and service delivery.

438. 210(d) Timeframe for Authorization Decisions

Results

Twelve of fourteen PIHPs scored below "Expected".

Recommendation

All fourteen PIHPs must develop and implement effective policies and procedures for standard and expedited authorization decisions, including procedures for extensions.

438.606 Source, Content and Timing of Certifications

Results

Three of fourteen PIHPs met requirements for Q90a, b1, & b2.
Seven of fourteen did not meet the requirement for Q90.b3.

Recommendation

Two factors support this as a statewide recommendation. 1. The requirements changed, necessitating one certification per submission, rather than one per year, as previously. 2. Neither the MHD nor half the PIHPs had a comprehensive process for tracking and maintaining these certifications. The following recommendation was made:

Develop a policy and procedure for the generation and maintenance of data certifications and batch logs to ensure full compliance with this requirement.

- Certificates are signed, with original maintained by the PIHP and a copy at MHD.
- A log of batches certified and transmitted to MHD is maintained by the PIHPs and MHD.
- Certificates are specific with respect to the batch they are certifying. The CFR requires concurrent certification of submitted data, implying that certificates should pertain to specific batches. The WAEQRO is aware that PIHPs make this connection apparent by noting the batches being certified on the certification letter.

2005 Subpart Results

To provide a complete set of scores for the current review period, the 2005 Subpart results reflect the 2004 scores of items that were not rescored in 2005, and (new) 2005 scores for all items that were rescored during this review period. The 2005 results exhibit the overall distribution of scores by PIHP, their common areas of both strength and improvement, and the percentage of change/improvement per PIHP. These results also reflect statewide improvement over time, and system-wide observations of strengths and recommendations for quality improvement.

Three graphics will be presented for each Subpart:

- **Pie Chart:** compares 2004 and 2005 scoring frequency for all PIHPs combined. Black wedges represent scores below 3, and white wedges represent scores at or above Expected (3 or above) performance. Annotations on each wedge specify the score level and the frequency of that score within the Subpart

- **Stacked Column Chart:** identifies each PIHP's distribution of scores (0, 1, 2, 3, 4, or 5). The total column height accounts for 100% of item responses. The PIHPs are arrayed by

performance from best to worst, moving from left to right across the chart. This ranking is based on the greatest number of scores at or above the Expected performance level. Below the chart, a data table displays the actual score count for each PIHP. These numbers drive the percentages in the stacked column chart.

- **Enrollment-weighted Table:** Three perspectives of the 2005 statewide Subpart scores are represented in this table: (1) comparison of a standard average and an enrollment-weighted average; (2) identification of strong and weak areas, based on weighted averages and a defined set of criteria; and (3) a comparison of those strengths and weaknesses with items selected in 2004 by MHD and WAEQRO, respectively, for possible corrective action, and as opportunities for improvement. Flagged items in this analysis form the basis of WAEQRO's recommendations for improvement in 2005.

  Enrollment-weighted scores
  Each PIHP's scores were weighted based on actual enrollment during the review period. For example, if PIHP "A" has 12% of the statewide enrollment, its item scores will receive a 0.12 weight. For each item, the PIHP score is multiplied by its respective weight, and 14 results are summed to obtain the "WA State Weighted Average". This enrollment-weighted score more accurately reflects statewide performance because an exceptional score in a large PIHP will affect more members than it would in a small PIHP.

  Strengths and Weaknesses
  Criteria have been established to help identify areas of strength and weakness at both the PIHP and State level. In the two right-hand columns, stars and flags designate items that meet these criteria. To qualify as strength, the statewide, enrollment-weighted score must be at or above a specified level (3.7), *and* a certain number of PIHPs (9) must have individual scores at or above this level. Items with scoring profiles meeting both criteria receive a green strength "star." An inverted approach is used for assigning red weakness "flags." These designate items having low statewide scores (below 3.0) along with underperformance by 7 or more PIHPs. The two criteria for each category capture not only aggregate statewide performance, but also variation among PIHPs that can be masked when focusing strictly on statewide performance, even when weighted for enrollment.

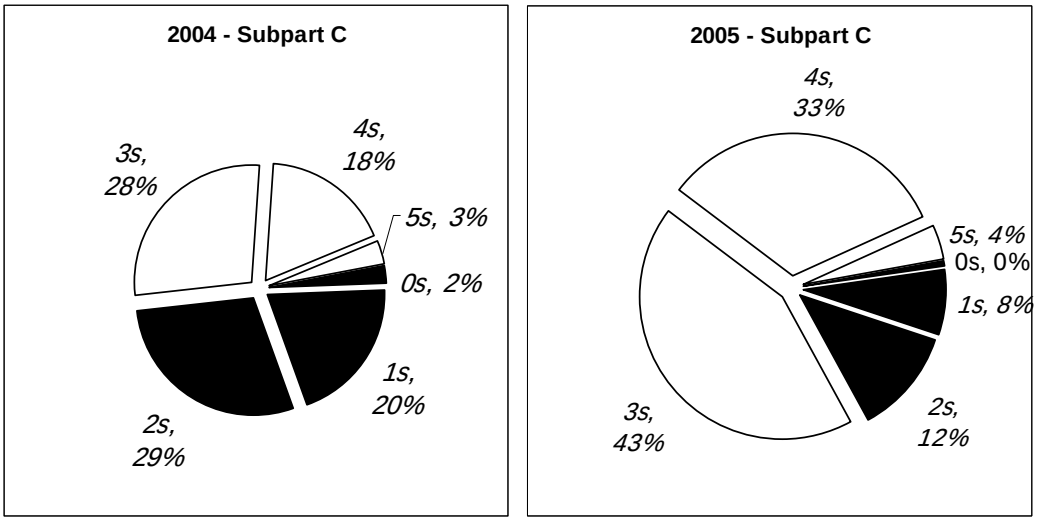
  As points of comparison, those items identified by MHD for corrective action, if the PIHP scored below 3 (Expected), are indicated by gray shading. Those Items reflected in the 2004 EQR report recommendations are underlined.

  The information displayed in these tables is supported by more detailed data that includes scores for each PIHP on each Subpart item scored in 2005 (see, **Appendix 1 – Detailed Enrollment-Weighted Averages)** for the complete dataset.

Subpart C – Enrollee Rights and Protections

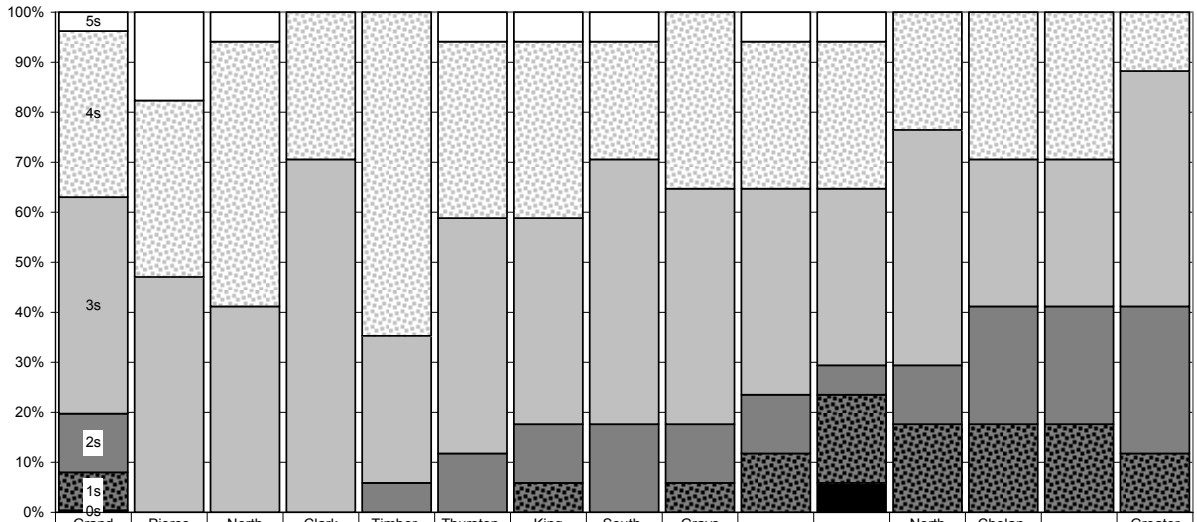
This section of the EQR included the determination of PIHP compliance with Federal and State regulations related to enrollee rights and protections, as well as verification that these requirements had been incorporated into their policies and procedures. Additionally, PIHP processes were assessed with respect to ensuring that their staff and Network Providers take these rights and protections into account when furnishing services to enrollees.

Figure 5: Subpart C 2004 – 2005 Score Comparison



The increased white area in the 2005 chart shows statewide PIHP improvement with respect to meeting the requirements of Subpart C. The diminishing size of the wedges for scores 0, 1, and 2 also indicates improvement. In fact, at the end of the 2004 review, 49% of Subpart C scores were at or above the Expected level of performance. After the 2005 review, 80% of the items meet that level, a 31% improvement from 2004. Twenty percent of the items in Subpart C remain below the Expected level.

Figure 6: 2005 Subpart C - Enrollee Rights and Protections
Distribution of Scores by PIHP



	Grand Total	Pierce County	North Sound	Clark County	Timber-lands	Thurston-Mason	King County	South-west	Grays Harbor	NEWRSN	Spokane	North Central	Chelan-Douglas	Peninsula	Greater Columbia
5s	9	3	1	0	0	1	1	1	0	1	1	0	0	0	0
4s	79	6	9	5	11	6	6	4	6	5	5	4	5	5	2
3s	103	8	7	12	5	8	7	9	8	7	6	8	5	5	8
2s	28	0	0	0	1	2	2	3	2	2	1	2	4	4	5
1s	18	0	0	0	0	0	1	0	1	2	3	3	3	3	2
0s	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0

As in the 2005 pie chart, this view of the scores shows that 80% of all Subpart C scores are at Expected, with 20% in the below Expected range. Also noteworthy is that 100% of 3 PIHPs' Subpart C scores are at Expected or above, while more than 40% of the scores for 3 PIHPs are below Expected.

According to the results of Subpart C, PIHPs prioritized enrollee rights and protections for quality improvements. Based on the scoring guidelines (see, **Attachment 4**), results indicate that, by and large, PIHPs have relevant policies and procedures in place; they also indicate that PIHP and Provider Network staff have received formal or informal training on 80% of the enrollee rights and protections elements. For the 20% of elements scored below Expected, various issues contributed to low scores: (1) policies and procedures were underdeveloped and/or missing key requirements, and (2) key PIHP and Network Provider personnel need training to increase knowledge and improve application of related policies and procedures.

2005 *Enrollment-Weighted Statewide Score Averages - Subpart C

Shading indicates 2004 Corrective Action Item
TEXT Underlined text indicates 2004 EQRO Improvement Recommendation

Item	Description	WA State Simple Average	WA State Weighted Average	Strength Stars Q(s1) Is State Wtd Average at least 3.7?	Strength Stars Q(s2) Did more than 9 PIHPs score at least 3.7?	Strength Stars Stars Items satis-fying both Q(s1) & Q(s2)	Weakness Flags Q(w1) Is State Wtd Average less than 3?	Weakness Flags Q(w2) Did more than 7 PIHPs score under 3?	Weakness Flags Flags Items satis-fying both Q(w1) & Q(w2)
				3.7	9	0 stars	3.0	7	0 flags
Q01	Accessible written information requirements P&P	2.9	3.4						
Q02	Policy guaranteeing enrollee rights	3.2	3.1						
Q03	Subcontracts require advising enrollees of rights	3.4	3.5						
Q04	Subcontractors publicly post rights in req languages	2.8	2.8				•		
Q05	Subcontractors assure client rights understanding	3.4	3.6						
Q06	Subcontractors protect exercising of client rights	3.1	3.4						
Q07	Policy re: other Federal/State law compliance	3.0	2.8				•		
Q08	Subcontracts include Federal/State law compliance	3.6	3.7						
Q09	Policies ensure specific rights compliance	2.8	2.6				•		
Q10	Subcontracts reference specific rights compliance	3.1	3.2						
Q11	PIHP monitors provider compliance with laws/rights	2.6	3.1						
Q12	PIHP P&P against prohibitions re: advising enrollees	3.6	3.6						
Q13	Enrollee payment liability protections	2.6	2.3				•		
Q14	PIHP P&P re: Mental Health Advance Directives (MHAD)	3.1	3.3						
Q15	Prompt law upadates to MHAD P&P	3.4	3.5						
Q16	Subcontractors req to have MHAD P&P	3.5	3.4						
Q17	Document clients informed of MHAD & choice	2.8	2.6				•		

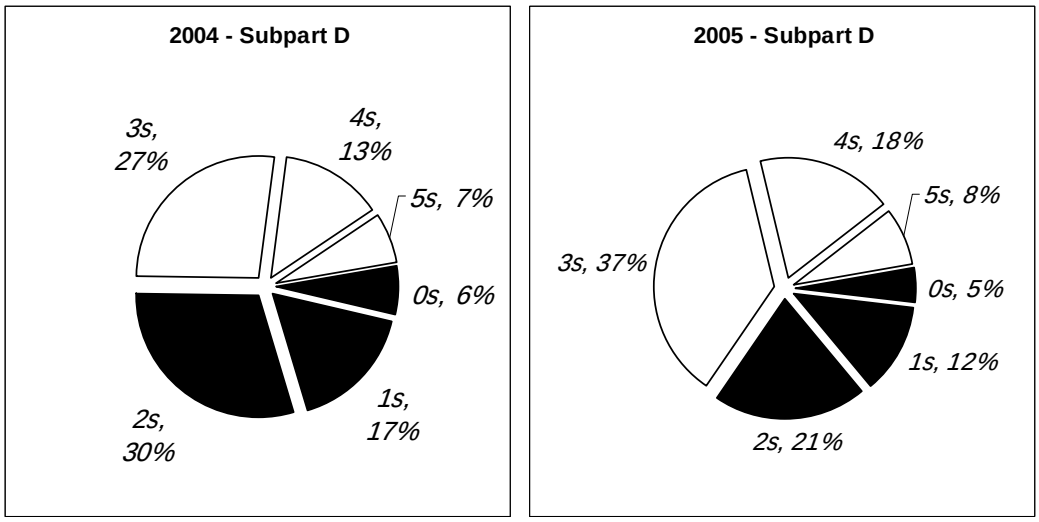
** as of June 2005, calculated April 2006*

The Subpart C enrollment-weighted average scores in the above table range from a low of 2.3 to a high of 3.7. Weighted average scores for five elements remain below expected, three of which were identified as 2004 WAEQRO improvement recommendations. There are no elements in this Subpart that meet the criteria of strength (star); however, there are also no elements that qualify as a weakness (flag). As discussed previously, the PIHPs prioritized implementing quality improvements in enrollee rights and protections, thereby improving scores in this subpart.

Subpart D – Quality assessment and Performance Improvement

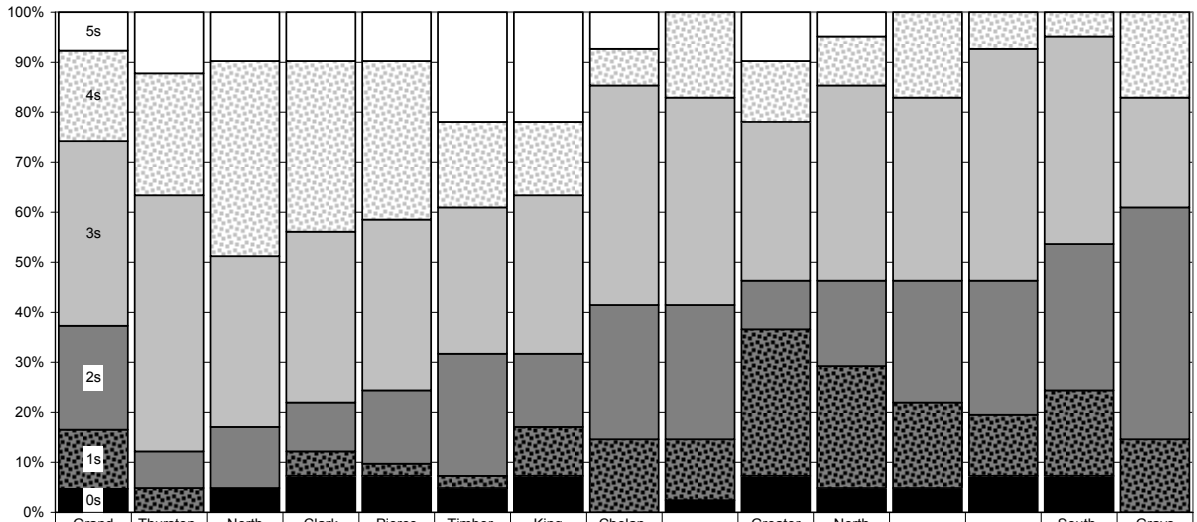
The Subpart D protocol sets forth specifications for Quality Assessment and Performance Improvement strategies that must be implemented to ensure the delivery of quality mental healthcare by the PIHPs. During the EQR, PIHPs were reviewed to determine their compliance with respect to Federal and State requirements related to the implementation of Access Standards, Structure and Operation Standards, and Measurement and Improvement Standards.

Figure 8: Subpart D 2004 – 2005 Score Comparison



The increased white area in the 2005 chart depicts a 16% increase statewide in scores above Expected.

Figure 9: 2005 Subpart D - Quality Assessment and Performance Improvement Distribution of Scores by PIHP



	Grand Total	Thurston-Mason	North Sound	Clark County	Pierce County	Timber-lands	King County	Chelan-Douglas	Peninsula	Greater Columbia	North Central	NEWRSN	Spokane	South-west	Grays Harbor
5s	44	5	4	4	4	9	9	3	0	4	2	0	0	0	0
4s	104	10	16	14	13	7	6	3	7	5	4	7	3	2	7
3s	212	21	14	14	14	12	13	18	17	13	16	15	19	17	9
2s	119	3	5	4	6	10	6	11	11	4	7	10	11	12	19
1s	68	2	0	2	1	1	4	6	5	12	10	7	5	7	6
0s	27	0	2	3	3	2	3	0	1	3	2	2	3	3	0

As in the 2005 pie chart, this view of the scores shows that 63% of all Subpart D scores are at Expected or above, with 37% in the below Expected range. Also of note is that no PIHP achieved 100% of scores at or above Expected. In addition, for 8 PIHPs, more than 40% of Subpart D scores are below Expected. These results confirm that Subpart D-Quality Assessment and Performance Improvement remains the most challenging Subpart.

Based on the statewide overall distribution of Subpart D scores and the scoring guidelines (see, **Attachment 4**), this chart indicates that for 37% of the elements scored, two factors contributed to low scores: (1) policies and procedures were underdeveloped and/or missing key requirements, and (2) key PIHP and Network Provider personnel need training to increase knowledge and application of related policies and procedures.

2005 *Enrollment-Weighted Statewide Score Averages - Subpart D

Shading indicates 2004 Corrective Action Item

TEXT Underlined text indicates 2004 EQRO Improvement Recommendation

Item	Description	WA State Simple Average	WA State Weighted Average	Strength Stars Q(s1) Is State Wtd Average at least 3.7?	Strength Stars Q(s2) Did more than 9 PIHPs score at least 3.7?	Strength Stars Stars Items satis-fying both Q(s1) & Q(s2)	Weakness Flags Q(w1) Is State Wtd Average less than 3?	Weakness Flags Q(w2) Did more than 7 PIHPs score under 3?	Weakness Flags Flags Items satis-fying both Q(w1) & Q(w2)
				3.7	9	2 stars	3.0	7	12 flags
Q18	PIHP monitors access and service availability	3.3	3.2						
Q19	PIHP monitors & reports network sufficiency changes	3.2	3.1						
Q20	PIHP manages network adequacy	3.1	2.9				•		
Q21	Second opinion mechanism	3.0	3.1						
Q22	PIHP has out-of-network P&P	2.7	3.1						
Q23	PIHP P&P re: out-of-network payment coordination	2.7	3.0				•		
Q24	PIHP P&P re: out-of-network cost to enrollee	2.5	2.4				•		
Q25	Ensures compliance with timely access standards	3.8	3.8	•	•	*star*			
Q26	Timely access standards in subcontracts	3.4	3.3						
Q27	PIHP oversight of provider timely access compliance	3.3	3.2						
Q28	Culturally competent services by MH Specialists	3.9	4.0	•	•	*star*			
Q29	Written & oral translation of client materials	2.4	2.5				•	•	*flag*
Q30	Ensure Interpreter availability	3.1	3.1						
Q31	Culturally competent subcontractor specialists	3.8	4.1	•					
Q32	Written and oral translation by subcontractors	2.4	2.5				•		
Q33	Monitoring of culturally competent services	3.1	3.2						
Q34	Sufficiency of provider network to meet need	3.0	3.0				•		
Q35	Changes in capacity and services reported to State	3.3	3.5						
Q39	Consistent authorization standards	3.1	3.4						
Q40	Authorization conducted by MHPs	2.6	2.4				•		
Q41	Monitoring of consistent authorization practices	2.6	2.7				•		
Q42	Adverse action notices meet requirements	1.9	2.2				•	•	*flag*
Q43	Standard authorization requirements	2.4	2.5				•	•	*flag*
Q44	Expedited authorization requirements	2.3	2.1				•	•	*flag*
Q45	Extension of expedited authorization request	1.9	1.6				•	•	*flag*
Q47	Protection against provider discrimination	2.8	2.5				•		
Q48	Policy re: excluded providers	3.4	3.2						
Q49	Confidentiality compliance	4.1	4.5	•					
Q50	Privacy compliance by subcontractors	3.6	3.7	•					
Q51	Privacy compliance subcontractor audits	2.4	2.9				•		
Q52	Pre-subdelegation evaluation	2.1	2.5				•	•	*flag*
Q53	Written subdelegation agreement	2.0	2.7				•	•	*flag*
Q54	Annual subcontractor subdelegation performance review	2.1	2.7				•	•	*flag*
Q55	Corrective actions re: subdelegation deficiencies	2.5	3.1					•	
Q56	Adoption of evidenced based practice guidelines	2.2	2.4				•	•	*flag*
Q57	Dissemination of practice guidelines	2.4	2.5				•		
Q58	Application of practice guidelines	1.6	1.5				•	•	*flag*
Q60	Performance measurement data submission	2.6	2.4				•	•	*flag*
Q61	Detection of over & under utilization	2.7	3.2						
Q62	Quality care to enrollees with special health needs	3.0	3.5						
Q64	Annual data submission to State	2.5	2.5				•	•	*flag*

** as of June 2005, calculated April 2006*

The Subpart D table above reflects the lowest and highest enrollment-weighted average score in all Subparts. The table shows that weighted average scores range from a low of 1.5 to a high of 4.5, a significant variation among PIHPs and throughout this Subpart. Subpart D has the largest number of elements and the most diversified subject matter of all

the Subparts, which may account for the deviation in scores. In addition, some subject areas and/or specific requirements may be more difficult to accomplish.

There are two elements in Subpart D, [Q25] and [Q29] that qualify as strengths (stars). At least 9 of 14 PIHPs had a score of 3.7 or above for each of these elements. Item [Q25] has a weighted average score of 3.8 and shows evidence that PIHPs are ensuring access to services within required timeframes. The second, [Q28], has a weighted average score of 4.0 indicating that culturally competent services are prioritized and implemented through the participation of Mental Health Specialists across the State.

There are a total of twelve identified weakness flags in Subpart D, signifying that a minimum of 7 PIHPs scored below 3.0 for related elements. Most of these low-scoring items are clustered under related requirements and include elements related to these factors:

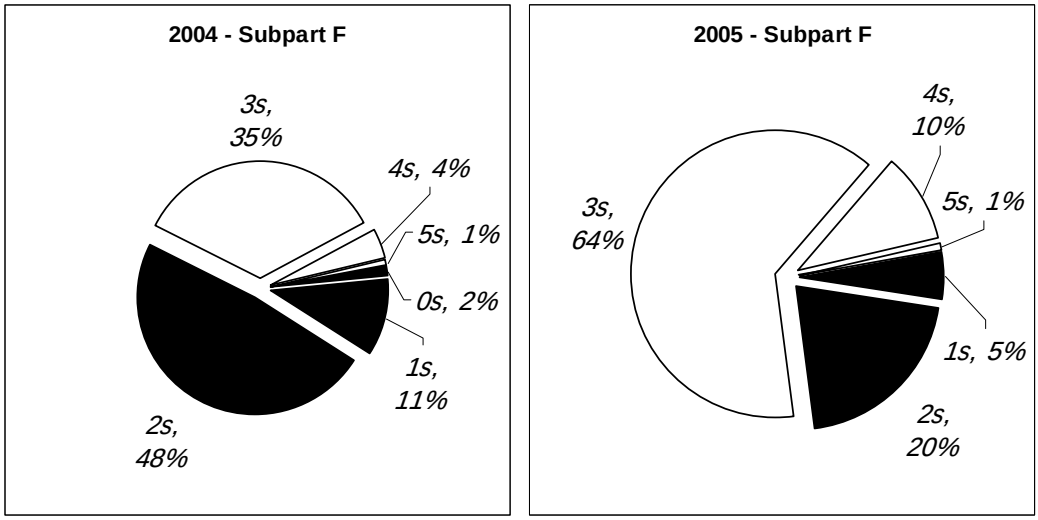
- Authorization Timeframes
- Sub-delegation of PIHP Functions
- Practice Guidelines
- Data Submission

Additional flagged elements include Adverse Action Notice Requirements, Out-of-Network Payment Coordination, Written and Oral Translation of Client Materials. Ten of these twelve elements were also identified as 2004 WAEQRO improvement recommendations, indicating that the majority of these elements remain a challenge.

Subpart F – Grievance System

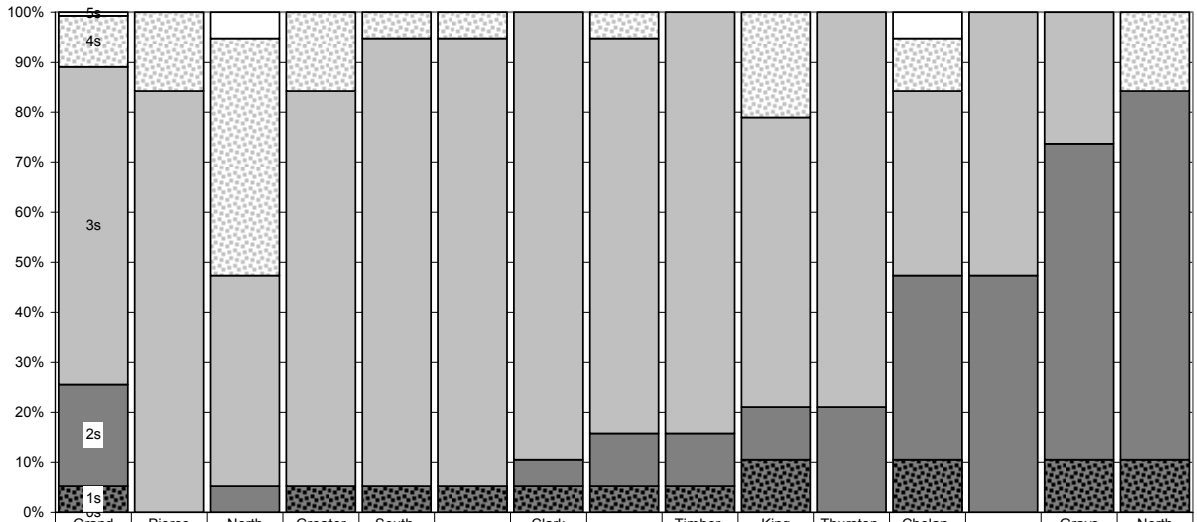
The Subpart F protocol requires that each PIHP have in place an enrollee Grievance System which includes a grievance process, an appeal process, and access to the State's fair hearing system. Accordingly, PIHP written grievance system policies and procedures were reviewed to determine whether required provisions and timeframes were accurately included. In addition, PIHP and selected Provider Network staff were interviewed to determine their knowledge and application of grievance system policies and procedures, and the extent to which they have been integrated into the region-wide system of care.

Figure 11: Subpart F 2004 – 2005 Score Comparison



The increased white area in the 2005 chart depicts a 35% increase statewide in scores above Expected.

Figure 12: 2005 Subpart F - Grievance System
Distribution of Scores by PIHP



	Grand Total	Pierce County	North Sound	Greater Columbia	South-west	Spokane	Clark County	NEWRSN	Timber-lands	King County	Thurston-Mason	Chelan-Douglas	Peninsula	Grays Harbor	North Central
5s	2	0	1	0	0	0	0	0	0	0	0	1	0	0	0
4s	27	3	9	3	1	1	0	1	0	4	0	2	0	0	3
3s	169	16	8	15	17	17	17	15	16	11	15	7	10	5	0
2s	54	0	1	0	0	0	1	2	2	2	4	7	9	12	14
1s	14	0	0	1	1	1	1	1	1	2	0	2	0	2	2
0s	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

As in the 2005 pie chart, this view shows that 74% of all Subpart F scores are at Expected and above, with 26% in the below Expected range. One PIHP scored at or above Expected on all items, more than half have less than 20% below Expected, and there are no scores of zero (0).

These results show that PIHPs concentrated on improving their grievance systems in 2005. In particular, they prioritized formal and informal training of PIHP and Provider Network staff. Based on the scoring guidelines (see, **Attachment 4**), results indicate that additional training for key personnel is needed to increase knowledge and application of policies, procedures, and related State and Federal requirements.

2005 *Enrollment-Weighted Statewide Score Averages - Subpart F

Shading indicates 2004 Corrective Action Item

TEXT Underlined text indicates 2004 EQRO Improvement Recommendation

Item	Description	WA State Simple Average	WA State Weighted Average	Strength Stars Q(s1) Is State Wtd Average at least 3.7?	Strength Stars Q(s2) Did more than 9 PIHPs score at least 3.7?	Strength Stars Stars Items satis-fying both Q(s1) & Q(s2)	Weakness Flags Q(w1) Is State Wtd Average less than 3?	Weakness Flags Q(w2) Did more than 7 PIHPs score under 3?	Weakness Flags Flags Items satis-fying both Q(w1) & Q(w2)
				3.7	9	0 stars	3.0	7	1 flags
Q71	Authority to file grievance	3.1	3.4						
Q72	Timing and Procedures for filing	2.7	3.0				•		
Q73	Timing of notice	1.9	2.0				•	•	flag
Q74	Administrative assitance for enrollees	2.7	2.8				•		
Q75	Grievance acknowledgement	2.8	2.9				•		
Q76	Appropriate grievance review personnel	2.9	2.9				•		
Q77	Special requirements for appeals	2.8	2.8				•		
Q78	Enrollee access to case file	2.9	3.2						
Q79	Included appeal parties	2.7	2.9				•		
Q80	Resolution and notification of grievances & appeals	2.8	3.0						
Q81	Content of Notice of Appeal Resolution	3.1	3.2						
Q82	State fair hearings requirements	2.6	3.0				•		
Q83	Expedied appeal resolution/prohibition against punitive action	2.8	2.7				•		
Q84	Denial of expedited resolution	2.9	2.9				•		
Q85	Use of State developed description in subcontracts	2.9	3.1						
Q86	Record keeping	2.7	3.1						
Q87	Review and quality improvement	3.1	3.4						
Q88	Rights upheld during pended appeal	2.8	3.0				•		
Q89	Rights upheld regarding disputed services	3.1	3.2						

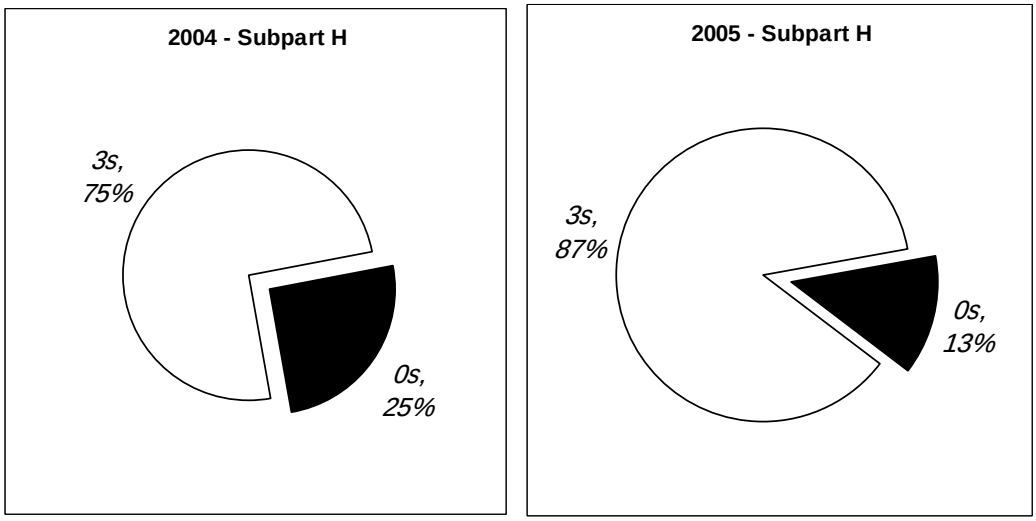
** as of June 2005, calculated April 2006*

The Subpart F enrollment-weighted average scores in the above table range from a low of 2.0 to a high of 3.4. Weighted average scores for eleven elements remain below expected; one is a flagged weakness identified by WAEQRO in 2004 as an improvement recommendation. There are no elements in this Subpart that meet criteria for a starred strength. As discussed previously, PIHPs prioritized improving the quality of their grievance systems. Results indicate, however, that this effort must be on-going, especially with respect to the timing of Notice of Actions. In addition, staff training is needed with respect to related policies and procedures.

Subpart H – Certification and Program Integrity

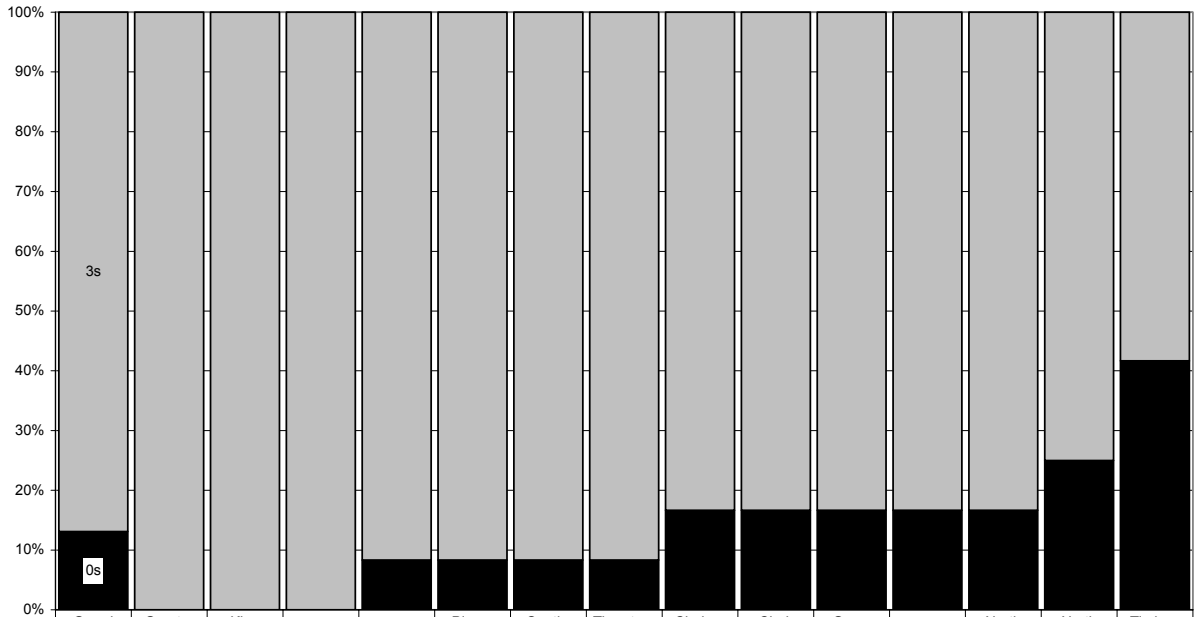
The Subpart H-Certification and Program Integrity protocol requires that, as a condition for receiving payment under the Medicaid managed care program, a PIHP must comply with applicable certification, program integrity, and prohibited affiliation requirements. To determine compliance, WAEQRO reviewed PIHP Data Certifications, Fraud and Abuse Compliance Plans, and other relevant documentation.

Figure 14: Subpart H 2004 – 2005 Score Comparison



The increased white area in the 2005 chart depicts a 12% increase statewide in scores above Expected (score of 3 for this Subpart).

Figure 15: 2005 Subpart H - Certifications and Program Integrity
Distribution of Scores by PIHP



	Grand Total	Greater Columbia	King County	Spokane	NEWRSN	Pierce County	South-west	Thurston-Mason	Chelan-Douglas	Clark County	Grays Harbor	Peninsula	North Sound	North Central	Timber-lands
3s	146	12	12	12	11	11	11	11	10	10	10	10	10	9	7
0s	22	0	0	0	1	1	1	1	2	2	2	2	2	3	5

As in the 2005 pie chart, this view shows that 87% of all Subpart H scores are at Expected, with 13% below. In addition, 3 PIHPs scored at Expected on 100% of Subpart H items, while 4 other PIHPs scored zero (0) on one element. According to these results, PIHPs achieved the highest combined statewide Subpart score in Subpart H-Certifications and Program Integrity.

2005 *Enrollment-Weighted Statewide Score Averages - Subpart H

Shading indicates 2004 Corrective Action Item
TEXT Underlined text indicates 2004 EQRO Improvement Recommendation

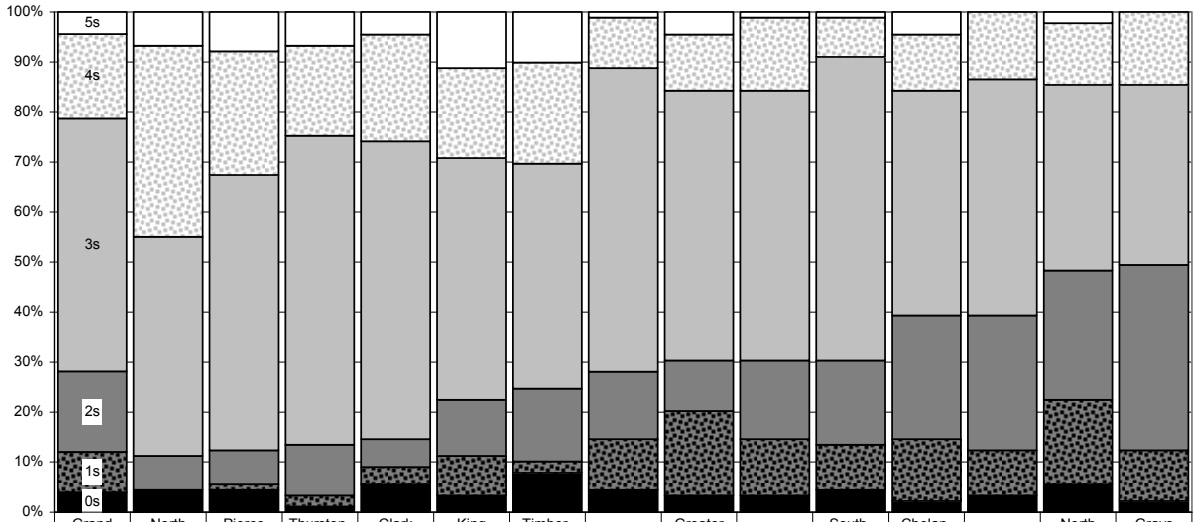
Item	Description	WA State Simple Average	WA State Weighted Average	Strength Stars Q(s1) Is State Wtd Average at least 3?	Strength Stars Q(s2) Did more than 9 PIHPs score at least 3?	Strength Stars Stars Items satis-fying both Q(s1) & Q(s2)	Weakness Flags Q(w1) Is State Wtd Average less than 3?	Weakness Flags Q(w2) Did more than 7 PIHPs score under 3?	Weakness Flags Flags Items satis-fying both Q(w1) & Q(w2)
				3	9	3 stars	3.0	7	1 flags
Q90.a	Source of certification	2.6	2.8		•		•		
Q90.b1	Data content certification	2.8	2.9		•		•		
Q90.b2	Certification content requirements	2.8	2.9		•		•		
Q90.b3	Certification timing	2.1	2.2		•		•		
Q91.b1	Written fraud & abuse p&ps/compliance plan	3.0	3.0	•	•	*star*			
Q91.b2	Accountable compliance officer/committee	3.0	3.0	•	•	*star*			
Q91.b3	Effective Compliance training and education	2.8	3.0		•		•		
Q91.b4	Effective compliance communication	2.4	2.1		•		•		
Q91.b5	Well publicized disciplinary guidelines	2.8	2.8		•		•		
Q91.b6	Internal audit provisions	1.3	2.3				•	•	*flag*
Q91.b7	Prompt response to offenses	3.0	3.0	•	•	*star*			
Q92	Prohibited affiliations with the Federally debarred	2.8	2.9		•		•		

** as of June 2005, calculated April 2006*

Because the maximum attainable score for this Subpart is 3.0, thresholds for stars were set differently than for other Subparts. The enrollment-weighted averages in the above chart range from a low of 2.1 to a high of 3.0. Three elements are designated as starred strengths, with one element flagged as a weakness. Starred items are in Program Integrity, which includes elements required in PIHP fraud and abuse compliance plans. The flagged weakness is also in the Program Integrity area and relates to PIHP internal audit provisions. Overall, PIHPs have excelled in meeting the requirements of this Subpart.

2005 - All Subparts

Figure 17: 2005 All Subparts
Overall Distribution of Scores by PIHP



	Grand Total	North Sound	Pierce County	Thurston-Mason	Clark County	King County	Timber-lands	Spokane	Greater Columbia	NEWRSN	South-west	Chelan-Douglas	Peninsula	North Central	Grays Harbor
5s	55	6	7	6	4	10	9	1	4	1	1	4	0	2	0
4s	210	34	22	16	19	16	18	9	10	13	7	10	12	11	13
3s	630	39	49	55	53	43	40	54	48	48	54	40	42	33	32
2s	201	6	6	9	5	10	13	12	9	14	15	22	24	23	33
1s	100	0	1	2	3	7	2	9	15	10	8	11	8	15	9
0s	50	4	4	1	5	3	7	4	3	3	4	2	3	5	2

Over 70% of scores on all Subparts statewide were at or above the Expected level of performance, with 10 of the 14 PIHPs achieving at least that performance or better. While the vast majority of scores were 3s, the best-performing PIHPs had significantly more 4s and 5s and fewer 0s and 1s, and one of those 10 PIHPs had only one score of zero. On the other end of the spectrum, lower-performing PIHPs had scores of 1 and 2 in much higher percentages. The percentage of scores at zero varied across the entire system with all PIHPs at about 3%; the only exception was one PIHP with about 8% zeros.

In summary, system-wide performance of PIHPs is squarely in the mid-range, as measured by their 2005 performance on the Subparts. Attaining minimum Expected performance requires that their policies and procedures accurately, completely, and consistently meet BBA and State requirements. Achievement of outstanding performance will occur as the culture of quality improvement evolves, which will lead to the provision of effective clinical care in an environment that consistently supports consumer rights and consumer-driven service delivery.

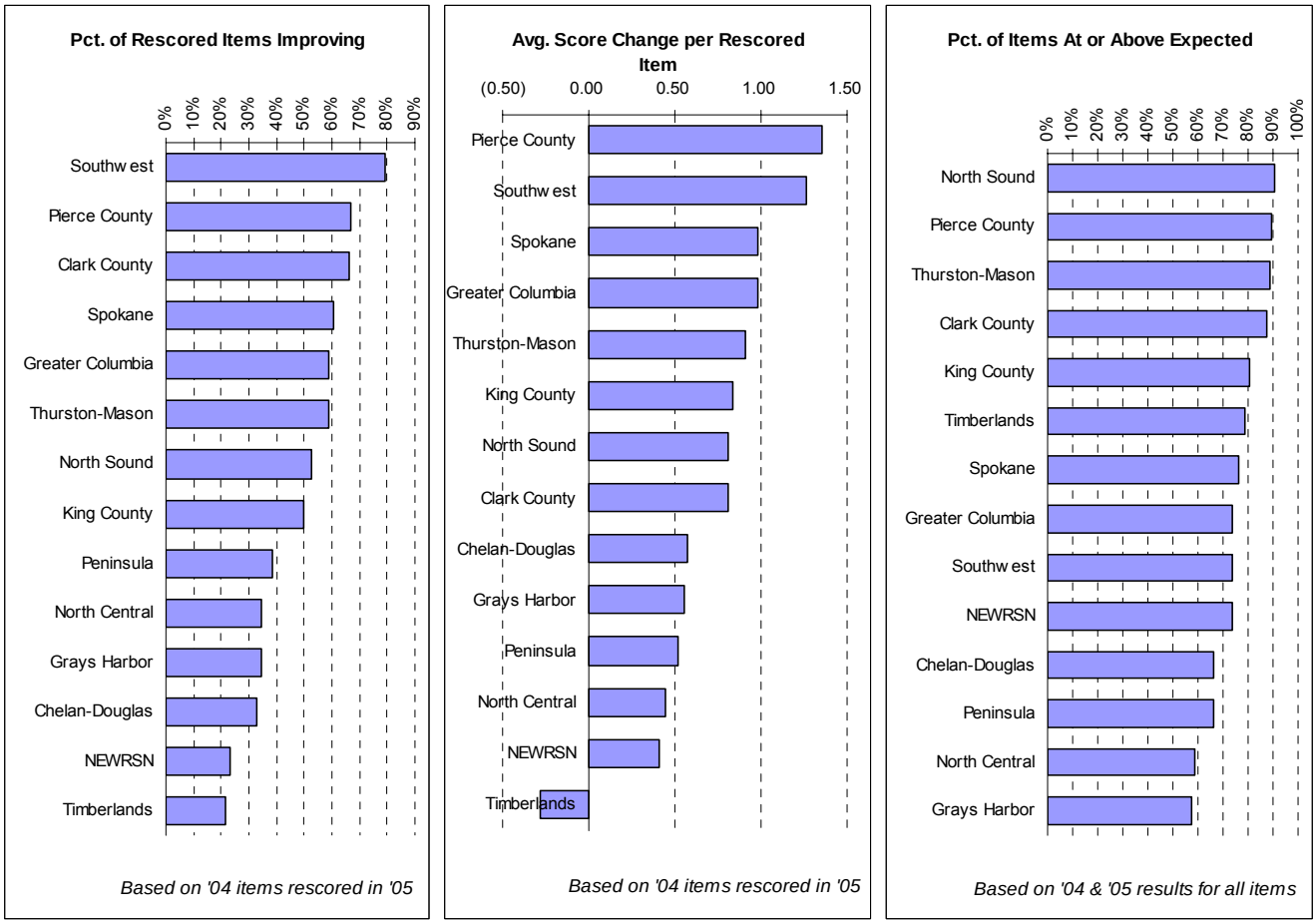
The chart below displays the average increase in score points for each 2004 WAEQRO Improvement Recommendation. PIHPs improved in all elements from 0.200 to 1.400. For instance, in element Q13, enrollee payment liability protections increased a combined average of 1.0 point on a six point scale from 2004.

Figure 18: 2005 System-wide Improvement on 2004 Recommendations

2005 – Performance Rankings

The following charts display three different approaches to categorizing PIHP performance.

Figure 19: Measures of Improvement



The first chart recognizes the most improved PIHPs. Top ranking goes to the PIHP showing the greatest percentage of Items with higher scores in 2005 than in 2004. This ranking method disregards the actual number of rescored Items.

The second chart displays the average score increase for each PIHP, based on all items that were rescored in 2005. PIHPs are ranked from greatest to least average increase in scores. For instance, Pierce County's average score change was 1.5 points per element rescored, using the 0-5 Subpart scoring scale. Average PIHP improvement is calculated by summing the total amount of movement from 2004 to 2005 between points on the scoring scale, and dividing that result by the number of rescored Items accounting for that change. Note that this ranking method also disregards the actual number of rescored Items for any individual PIHP.

The third chart recognizes PIHPs with the best overall performance at the end of the 2005

review year. Overall performance is defined as the greatest percentage of item scores at or above the Expected performance level (3, 4, or 5). This approach uses all item scores for every PIHP, not only rescored items as in the prior two methods. This approach is unique in its "snapshot" perspective, contrasted with the "trend" viewpoint presented in the first two methods.

In brief, varied levels of improved PIHP performance and, in turn, continuous quality improvements, are evident throughout the statewide mental health system.

2005 Subpart Summary and Recommendations

Strengths

- PIHPs prioritized implementing quality improvements in Subpart C, thereby improving policies and procedures, and ensuring that direct service staff become more knowledgeable about enrollee rights and protections.

- Although elements in this Subpart (D) remain the most challenging for PIHPs, it also is the Subpart for which PIHPs have attained some of their highest combined scores. Areas of excellence in Subpart D include confidentiality compliance, effective use of Mental Health Specialists, and ensuring compliance with timely access to services.

- PIHPs have prioritized further development of their grievance systems. In particular, they have provided a degree of staff training and ensured staff access to grievance system policies and procedures, as evidenced (during interviews) by staff knowledge of procedures and/or resources for information.

- The implementation and issuance of Notice of Actions are occurring in several PIHPs, an important step in ensuring that the managed care entity is responsible for decisions regarding denials of care.

- As previously discussed, PIHPs have achieved the highest combined score percentages in Subpart H. In general, PIHPs have successfully implemented all requirements related to Data Certifications.

- With regard to Fraud and Abuse Compliance Plans, PIHPs have successfully met the majority of requirements.

Recommendations

The recommendations below describe opportunities for improvements per Subpart that the WAEQRO team identified during the review process. Because of the time lapse between the review year and completion of this report, many of these items have likely been addressed.

- The WAEQRO recommends that the State provide clarification of the standard regarding posting of enrollee rights and translation of client materials, including specifics of language requirements and documents included, via written policy and

procedure.

- The WAEQRO recommends incorporating BBA requirements for authorization decision timeframes into PIHP policies and procedures, and that the PIHPs ensure that they are effectively implemented.

- The WAEQRO recommends that PIHPs develop and implement processes for sub-delegation that include all BBA requirements, including pre-delegation assessment, contracting, and monitoring activities that ensure that the subdelegated functions are being conducted reliably.

- To reduce duplicative efforts and increase effective resources, the WAEQRO recommends that PIHPs collaborate in developing practice guidelines and provide training to Provider Network staff regarding their application.

- Because there remains confusion as to the authorization and service decisions that are considered denials and when a Notice of Action should be issued, the WAEQRO recommends that the State clarify the operational definition of a denial for inpatient and outpatient services, and standardize processes for issuing, tracking, and monitoring Notice of Actions. WAEQRO also recommends that PIHPs increase their oversight of Provider Network screening and intake procedures to ensure that denials are not occurring without PIHP knowledge and involvement.

- Implement formal procedures to prevent and detect internal fraud and abuse.

- PIHPs should create procedures to officially adopt and approve new and revised policies and procedures. Ensure that each policy contains all required provisions referenced in the Code of Federal Regulations (CFR) and include dated signatures of PIHP officials or designees, date(s) of revisions, and effective date.

- Prioritize PIHP-provided training for Provider Network direct service staff to ensure understanding, skill development, and implementation of new policies, procedures, and mechanisms.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION RESULTS

Background 2004

In 2004, the Mental Health Division's Performance Data Group selected PIP study topics and provided PIHPs with general direction for their use. Accordingly, PIPs were to address (1) compliance with HIPAA data transmission requirements, and (2) Consumer Participation in Treatment Decisions – data for which is annually gathered by the State in a consumer satisfaction survey.

PIHPs did not have a clear understanding of how to develop locally-relevant PIPs, if indeed their performance in these areas warranted a PIP at all. Most PIHPs implemented tracking systems

to satisfy the data transmissions requirement; reliability of results was understood to be high since data was aggregated and measured by the State. For the clinical PIP requirement, many PIHPs again annually tracked performance on the Consumer Satisfaction Survey; some redesigned provider contracts to require that agencies develop a plan to focus on this issue, and others created plans to investigate their results and develop improvement strategies.

APS changed the way it reviewed PIPs following the 2004 review. In 2004, state-defined PIPs were reviewed and scored as part of the Subpart review process. Three items on the Subpart review tool addressed the general requirements for conducting PIPs. Scores ranged from 2 to 5 on the 0-5 scale used for most Subpart standards, with half the scores from all three questions at 4. A score of 4 is considered above Expected; however, the more detailed PIP review in 2005 produced substantially different results.

2005 Review

Each PIHP was to have four Performance Improvement Projects (PIPs) in progress this year: the two previously identified by the State in 2004, and an additional two of their own choosing, one Clinical and one Non-clinical. APS reviewed the two PIHP-selected PIPs.

The Review Process

The WAEQRO sent a document request to all PIHPs prior to the start of site visits. This request included instructions for compiling supporting documentation, a copy of the validation tool, and guidelines for structuring PIPs. PIHPs were given three weeks to submit their PIPs.

Recognizing that the CMS protocol was new or unfamiliar to the PIHPs, 2005 was the first year it was used to conduct the PIP review. Thus, per the WAEQRO focus on continuous quality improvement, a scoring system calibrated to “Yes/No/Partial” was adapted to the CMS validation tool. The CMS tool was applied to both PIPs prior to each site visit, except for rare instances where insufficient information precluded its application.

During site visits, discussion was held with each PIHP regarding strengths and weaknesses of their PIPs. APS also provided general technical assistance, which included reviewing the CMS protocols, defining terms, and clarifying expectations. Each PIHP was provided a copy of a PIP plan from another state as an example of a well-structured PIP, and each was referred to the CMS protocols for conducting and validating Performance Improvement Projects. Final PIHP reports included completed validation tools in addition to a performance summary.

2005 Results

In general, APS found that PIHPs continued to have minimal understanding of CMS PIP protocols and process. With some notable exceptions, plans were brief, incomplete, and lacked necessary detail. More often than not, documentation submitted failed to provide evidence that PIHPs had worked within a committee context to develop and implement their plans.

Because the majority of PIPs reviewed did not meet expectations for most steps of the validation process, APS has chosen to report a summary of strengths and difficulties of the 2005 PIPs. Using the summary table included in the individual PIHP reports, a review is provided below of the major technical assistance themes addressed during the site visits. APS observed positive movement across the mental health system.

- Many of the clinical study topics had great potential; with improved data analysis and refinement, they could provide important improvements to the care provided to consumers.
- All PIHPs were receptive to the technical assistance provided and are requesting a statewide training; requests for technical assistance regarding PIP development have been received by the PIHP since the individual reports were completed.
- One PIHP has hired a data analyst, and others are considering options for obtaining the same skill set; this function will greatly enhance their ability to understand their data and make considered decisions about priorities for improvement activities.

Figure 20: PIP Validation Summary

Step	Discussion
1. Selection of study topic	• Most PIHPs did not select study topics based on analysis of their ongoing data review; Some chose interventions (clinical and process) in which they had interest and then looked for a problem to which that intervention would relate; • The PIHPs were unclear as to the definition of "clinical" vs. "non-clinical" • The non-clinical PIPs were often "back office" operations that were worthy of attention but did not significantly impact a process or outcome of care
2. Definition of study question	• The non-clinical projects were most often structured as compliance tracking exercises; • Questions most often were not structured as scientific inquiry, but rather stated as, "How can we accomplish ___?"
3. Selection of study indicator	• Indicators were generally vague, too broad, or not directly related to the study question • Only 1 PIHP was able to correctly define a numerator and denominator
4. Use of representative and generalizable study population	• Study populations, for the most part, were not well-defined • Number of Medicaid consumers included or affected was not addressed in most PIPs
5. Use of sound sampling techniques	• Sampling was rarely attempted, and when it

Step	Discussion
	was, no information was provided that validated the reliability of the sample size or sampling technique
6. Use of reliable data collection processes	• Data collection descriptions, with a few exceptions, were brief, lacked detail, and did not address the extent to which the data would be reliable
7. Implementation of intervention and improvement strategies	• One common difficulty was an attempt to implement multiple "solutions" at the same time, but without a system for identifying the real impact of any one of them in particular; • Most projects were not far enough along to have implemented interventions • Few PIHPs identified plans to ensure that proposed interventions would be implemented consistently as designed.
8. Analysis of data and interpretation of study results	• Data analysis plans were vague or not provided; many statements such as, "The X Committee will review the information regularly and make recommendations"
8. Creation of a plan for real improvement	• Not addressed in most; none of the projects were far enough along to assess the results and plan to ensure continuation or increased improvement
9. Achievement of sustained improvement	• None of the projects had progressed to this step

The WAEQRO strongly urges the Mental Health Division to sponsor training for their staff and PIHP senior and quality management staff.

PERFORMANCE MEASUREMENT RESULTS

In the state of Washington, Performance Measures evaluated by the WAEQRO are State-defined. These measures are:

- **Medicaid Penetration rates** – for community outpatient services by age group;
- **Medicaid Utilization rates** – for community outpatient services by age group; and
- **Consumer Survey Results** – from the Mental Health Statistics Improvement Program (MHSIP) Youth and Family Services Survey.

Medicaid Penetration and Utilization rates are calculated at the State level and derive from data collected from the PIHPs through their normal data submissions. The Consumer Surveys are conducted by the Washington Institute for Mental Illness Research & Training (WIMIRT). The Adult Consumer Survey and the Youth and Family Services Surveys are each conducted on alternating years. This year (2005) the Youth and Family Services Survey is being conducted.

WAEQRO examines both the PIHPs and the State to gain a reliable perspective on results published by the State. The accuracy of data submitted by the PIHPs is assessed through the Encounter Validation process. Validation of calculation methodologies for the MHD and WIMIRT's processes and procedures consists of interviews with key MHD and WIMIRT personnel and reviews of their calculation and measurement processes.

Specific topics related to data submission and client tracking were discussed at the site visit with PIHP Information Technology (IT) staff as a follow-up to last year's report.

2004 Performance Measure Review

The 2004 evaluation of the State's Performance Measures (PMs) provided an initial, baseline view of systems and processes used to create and track the measures being evaluated.

Data from the Information Systems Capability Assessment (ISCA) tool as well as interviews concerning the Performance Measure Validation tool and the Survey Validation tool (where appropriate) provided the foundation upon which WAEQRO based its conclusions.

The Performance Measures were defined by the state Mental Health Division; WIMIRT was responsible for conducting the surveys and reporting the results. The PIHPs' responsibility in this system was to provide accurate, complete, and timely data.

Each PIHP was given a composite score from the completed Performance Measure Validation tools in each of the five main sections of the tool. Results of the individual PM tools were included in the individual PIHP reports. The final statewide report contained a compliance statement, a description of each identified PM issue, and a section relative to the system used for collection and reporting.

2004 Results and Recommendations

Penetration Rates: Medicaid Population

Substantially Compliant

Issues causing this PM to be scored as substantially compliant rather than fully compliant concern the level of granularity used when capturing enrollment information and the lack of controls over the submission of encounter data.

Though calculating the denominator presently calls for use of an unduplicated member year, the WAEQRO is encouraging the use of member months; doing so significantly increases accuracy and flexibility. For example, when using the unduplicated member year, an individual moving from one PIHP to another can only be counted by one entity; if reported by both PIHPs, the denominator is overstated by 1. However, using member months in that same example results in the individual reflected as a member of each PIHP for the appropriate number of months.

WAEQRO also commented on the lack of controls necessary to ensure full reporting of encounters in the system. Such lack could seriously impact the numerator used in this calculation. Largely capitated, the system lacked the normal motivations one would find in a fee-for-service environment that directly rewards the submission of encounters. Also noted was that incorrect implementation of data cut-off dates could have a negative impact on accurate reporting of the numerator.

Outpatient Utilization: Medicaid Population Served

Not Valid

Factors causing this measure to be scored as not valid included evidence of missing encounters, lack of controls to ensure that only Medicaid services are included in the numerator, and a general lack of control and oversight to ensure that system data accurately represents work accomplished.

During last year's on-site visits, WAEQRO took a small sample of client data from each PIHP; data related to these clients was then extracted from the State database. Nine percent (9%) of these client encounters were not found in the State system. Missing data severely impacts the accuracy of any measure.

In 2004, as a result of problems revealed by a data sampling process, APS identified a concern related to the controls utilized by MHD to ensure that the distinction was maintained between Medicaid and non-Medicaid data. At the time, further investigation did not dispel this impression. During the 2005 review, however, additional information was brought to light that enabled APS to perform the query required to ensure a Medicaid-only dataset, thus removing concern about MHD's related controls.

WAEQRO also commented on the lack of controls necessary to ensure full reporting of encounters in the system. This comment is the same as previously stated for the Medicaid Penetration rate. Lack of controls in this area could seriously impact the numerator used in

this calculation.

Youth and Parent Perception of Quality and Appropriateness of Care, and Adult Perception of Quality and Appropriateness of Care

Valid

These two measures reflect surveys conducted and reported during alternating years. Sampling is fairly representative of the State and, to a lesser extent, the PIHP level. Based on PIHP request, over-sampling is occasionally done to clarify a particular area. WAEQRO noted that opportunities exist in sample selection that could possibly lead to beneficial results for some of the larger provider agencies in each PIHP.

The Performance Indicator Calculation System

In 2004, performance measures were derived from multiple data systems of varying complexity. Data in some of those systems had previously come into question, and at least one system was being replaced to help resolve such matters. The data collection task was more complex than necessary; APS recognized that until there are requisite changes in the systems, little could be done to address this matter.

The code used to calculate performance measures was evaluated and found to be sound. Moreover, staff members who analyze the data are competent and understand their environment.

2005 Performance Measure Results

This year's PIHP interviews were based on issues identified in 2004. Discussion and responses with respect to specific topics were documented in the individual PIHP reports. A compilation of trends and their implications is presented here.

1. **The mapping of non-standard codes**. WAEQRO sought to gain a more thorough understanding of methods employed by the PIHPs to ensure that correct codes are used and submitted to the State. Nine of the 14 PIHPs had well-established methodologies and/or documented processes and procedures to guide their provider network in this task. Five PIHPs were given the recommendation to document a procedure to ensure that this activity takes place in a correct and consistent manner.

2. **Unique member ID.** All PIHPs used appropriate methods to manage duplicate member IDs. However, PIHP understanding of the Consumer ID definition is unclear. The definition of this term in the State Data Dictionary (DD) is ambiguous; for example, the definition states that the Consumer ID is the identifier established by the contractor. WAEQRO understands that the Consumer ID is assigned by the PIHP, though the contractor makes the initial determination as to whether individuals presenting themselves for service are previously-defined consumers. The DD definition also indicates that, once the ID has been submitted to the MHD-CIS, it is never deleted, and that it should be used on all transactions required by the consumer.

The CMS protocols lead WAEQRO to conclude that the Consumer ID should be unique so that services can follow an individual to the point of receipt. This suggests use of a statewide Consumer ID. However, the Consumer ID used in this State is PIHP-specific. Thus, if a consumer lives in one PIHP service area, then moves to another, one is unable to track the consumer's services if a new Consumer ID is required in the second PIHP. Moreover, if an individual resides over time in multiple PIHP areas and receives services in these areas, the Consumer ID cannot be considered unique if that individual now has a different one in each service area.

3. **Tracking across product lines.** With the fairly recent requirement that Medicaid monies now be used only for Medicaid services, PIHPs need a way to track services by funding source. Thirteen PIHPs currently have this capability.

4. **Tracking individuals through enrollment, disenrollment, and re-enrollment.** This matter was clarified during site visits to ensure PIHP understanding of the complexities of this issue. Although an official Medicaid process not used by the State is defined as "disenrollment," the WAEQRO was focused on a different situation that can be described with the same term. That is, when an individual eligible for Medicaid becomes ineligible for some reason, or becomes eligible again after a period of ineligibility, is the system employed by a PIHP capable of tracking this consumer's activity? The answer affects accurate reporting of membership, calculation of member months, and the numerators for penetration and utilization. Twelve of the 14 PIHPs had this capability; two lacked the capability, or were not enforcing the requirement that providers check eligibility on a monthly basis and report changes in a diligent manner.

5. **Calculating member months.** In 2004, the WAEQRO encouraged the PIHPs and the State to consider calculating member months. The level of granularity offered by calculating member months facilitates comparisons between PIHPs and between the State and other entities. Per member per month (PMPM) measures are commonly used in the managed healthcare industry, and member month data allows for more accurate utilization and penetration rate calculation.

Results varied; two PIHPs were calculating and using member months in management reports, thus enhancing their ability to understand a wide variety of performance measurement relationships.

Of the remaining PIHPs, four were experimenting with member month calculations and trying to understand their use. Four were evaluating calculation methods, and four PIHPs were not considering their use or calculation.

6. **Member database.** A member database is a foundational tool for any managed care organization. Although there were many complaints about timeliness and accuracy of data offered by the State for this purpose, such data was being used by some PIHPs with a fair degree of reliability. Thus, concerns seemed more related to complexity and an understanding of the use of this data to PIHP benefit. Since last year's review and recommendations, substantially more PIHPs are using a member database. Issues of accuracy and timeliness remain, but they are predictable and manageable. In all, 11 of the

PIHPs are now using the data made available by MHD for a member database; three are not.

In 2005 the WAEQRO saw significant positive change across the State relative to issues identified in the first round of reviews. This was one such issue. It was noted that PIHPs had been working together to make progress on items such as designing and using a member database. APS views such quality improvement activity as a smart leveraging of resources.

7. **Provider database.** All PIHPs collect provider data as required by the State Data Dictionary; however, in many cases, that set of data is too limited for the task of managing a provider network at the level of detail and timeliness required in a managed care environment. Among the State PIHPs, 13 have a provider database, one does not, and only two use their database as more than a collection of information. Thus, a recommendation was made to all PIHPs that effort be made to create a more comprehensive and multi-functional provider database to manage issues such as network adequacy.

8. **Data easily under reported.** WAEQRO asked each PIHP to explain its policies and procedures when accessing an out-of-network provider, to ensure that data related to Medicaid encounters is correctly entered into the PIHP system. This had been identified as a factor that can lead to the under-reporting of encounters. In all 14 PIHPs, there were no adequate provisions for such a scenario. It was recommended that a policy and procedure be developed to ensure that these encounters are captured in the future.

Validation Results

PIHPs are responsible for submitting timely, accurate, and complete data that drives the performance measures. The encounter validation conducted in this year's review plays a significant role in the performance measure evaluation results. In 2004, from a sampling of encounters reviewed, only 91% could be matched. In that review, the sample size was not statistically based; other issues also were thought to have impacted the results. APS anticipated that this year's more comprehensive and statistically valid study would yield more positive results. For 2005, however, the State's encounter match rate was 83.15%; PIHPs ranged from a 42.78% match to a 99.39% match. Multiple issues may be driving this match rate; the Encounter Validation section of this report offers more detailed information on this subject. Based on the individual PIHPs' performance on the encounter validation, the following scores were given in the Performance Measure section (questions 60 & 64) of subpart D:

EV-PM Translation	
EV Match	**PM Score**
>99%	5
>97-99%	4
>95-97%	3
>93-95%	2
>90-93%	1
0-90%	0

Penetration Rates: Medicaid Population

Substantially Compliant

Issues concerning this measure remain largely unchanged from last year. Accuracy of the denominator continues to come into question. Use of the unduplicated member year is far less granular than other types of member month calculation. From interviews conducted both this year and last, the WAEQRO is aware that issues are more complex than can be addressed by a recommendation in this report. For example, data systems used by other entities are a factor, as are accounting systems used elsewhere in State government. Apart from those matters, problems remain with respect to controls used to ensure accurate data entry into the system. More specifically, clients and encounters that were Medicaid at the PIHP record level were not found in the State data.

Significant progress was identified in the overall system controls used to ensure accuracy and completeness of data. A number of PIHPs implemented fairly comprehensive audits similar to those used by WAEQRO in the Encounter Validation. These efforts have shown immediate results for those PIHPs. The more such reviews are conducted, the more accurate the State's data. This increasing level of accuracy has both performance measurement and financial implications for the PIHPs.

Outpatient Utilization: Medicaid Population Served

Not Valid

This year's encounter validation result is the primary reason this item remains scored as Not Valid. Last year, 9% missing seemed large; this year, at 16.85%, close to double that number is missing. There is a direct relationship between this measure and those missing encounters. Until the system's performance level increases in the area of data collection, it will be hard not to see an impact on the validity of values reported in this measure.

While system controls remain a concern, there has been system-wide improvement (as stated in the measure above). The controls employed by the system are only a part of the problem. Other issues need to be addressed relative to the State's data system, the standards employed, and structure of the data. Further detail on this topic may be found in the Encounter Validation section of this report.

Youth and Parent Perception of Quality and Appropriateness of Care, and Adult

Perception of Quality and Appropriateness of Care

Valid

These two measures are surveys; each conducted and reported on alternating years. Sampling is fairly representative of the State but to a lesser extent at the PIHP level. Over-sampling is done occasionally, based on request by a PIHP for a clearer picture of a particular area. It was noted that opportunities exist in sample selection that could possibly lead to beneficial results for some of the larger provider agencies in each PIHP.

There were no changes to this system since the last review. The survey methodology employed is sound and the sampling used is valid. The most problematic area of the surveys is sampling. Techniques are being explored and over-sampling by request continues.

The Performance Indicator Calculation System

During the 2005 review period, changes were taking place in the MHD's performance indicator calculation system. Most will be reportable in the 2006 review cycle. Some noteworthy changes include the following.

- The Mental Health Division has contracted with an external entity for calculation of performance measures. The code used by this external entity is the same as that evaluated in last year's review. It was found to be sound at that time, and there is no reason to alter that finding.
- The contracted entity has in place a disaster recovery system that now protects this data and its related calculations.
- Historically, the State has used dynamic data sets that preclude reproducing performance measures. The reproducibility of results is being addressed: data sets for calculation of the measures are being frozen and archived.
- The contracted entity and the State are discussing the next contract, which will include documenting the process used to calculate the measures and developing a data dictionary specific to these calculations.
- In 2004, it was noted that the process for collecting data used in the performance measures is more complex than it should be. The method of extracting data remains complex and undocumented in 2005, but steps are being taken to address this issue.

In all, the steps being taken and those that are planned will have very positive outcomes for this system. WAEQRO noted that many of the results and recommendations made in the 2004 review have been addressed or are at least in the planning stage.

2005 Performance Measure Recommendations

1. The WAEQRO recommends that all PIHPs maintain detailed provider data in some type of secure, sharable database and develop strategies for keeping the data current. Design and implementation of management tools to maximize value of the data is critical. Such real-time information availability as network adequacy, access to care, or tracking credentialing, require using the database to guide a variety of management decisions on an ongoing basis. Keeping it as a repository of increasingly outdated information to access periodically is not an effective use of this tool. Attention to such critical network management practices would improve overall consumer care.

2. The WAEQRO recommends that the PIHPs document the requirement for encounters easily under-reported in policy with a process or procedure to ensure that encounter data is not lost due to unique circumstances.

3. The WAEQRO continues to encourage PIHPs and the State to consider calculating member months. The level of granularity offered by calculating member months facilitates comparisons between PIHPs and between the State and other entities. Per member per month (PMPM) measures are commonly used in the managed healthcare industry, and member month data allows for more accurate utilization and penetration rate calculation.

4. WAEQRO continues to stress the need for reproducible performance measure calculations. To enable this functionality, processes and procedures must be sufficiently documented so as to allow another entity to successfully reproduce the results without any other form of guidance. In addition, the methods employed to extract data used in calculating the performance measures needs to be defined and reproducible. While the EQRO recognizes that these issues are being addressed, it is critical to keep the recommendation current until it is completed

ENCOUNTER VALIDATION

Conducting an Encounter Validation is new for the 2005 review and involves three complementary sets of activities:

1. Review of the State's dataset for accuracy and completeness;

2. Comparison of select data fields in the State's management information system (MIS) against the clinical record to ensure that all data submitted by the providers is accurate, complete, and contains supporting documentation; and

3. Comparison of the clinical record against the State's data to ensure that all required data was submitted.

The timeliness and accuracy standards are published in the State's Data Dictionary; the completeness standards and the data fields to be validated were defined by the State and will be published with the validation results in the second quarter of 2006. The time period for the review is the State's Fiscal Year 2005 (July 1, 2004 – June 30, 2005).

To accomplish the first of these activities, a simple random sample of encounters was drawn from qualified clients (those with at least one Medicaid service during the defined period of the review). To determine an adequate sample size, APS used the 'Sample Size Calculator' found on The Survey System web site: www.surveysystem.com/sscalc.htm. For fiscal year 2005, there were 3,024,038 Medicaid encounters.

The calculator determined that a sample size of 411 encounters would ensure a confidence level of 95% and a confidence interval of +/- 5 points, enabling the WAEQRO to draw valid conclusions about the accuracy, timeliness, and completeness of the data. Because it would be easier to request records at the client level, it was calculated that a draw of 30 client records from each PIHP would yield at least 411 encounters from each. A review of 10 randomly selected record sets was completed, and the set that was the most well-rounded was selected for use (a record set included a minimum of 411 encounters from each of the 14 PIHPs).

To accomplish the second activity, an additional 411 encounters were collected by the WAEQRO from agency providers visited in the field. Five records were collected from each of the two visited providers. The WAEQRO checked to ensure that records selected in the field were not part of the original records request and that there were qualifying Medicaid encounters for the review period. These records were either hand-carried from the provider or shipped to the WAEQRO after the visit.

Phase I: Review of State's Dataset

The State's data was comprised of 113,188 consumers, with 3,024,038 encounters within the dataset.

Phase I required basic measurement and evaluation of the data. The first category evaluated was Outpatient Service. Those data elements achieving 100% compliance are displayed in summary tables; those with varying performance are displayed and discussed in more detail.

Figure 21: Phase I – Table 1

Encounter Validation Phase I		
Data Element	**Data Standard**	**Statewide**
Outpatient Service		
Reporting Unit ID *(Contractor ID or RSN ID)*	100% valid, non-missing	**100.00%**
Claim Submit Identifier	100% valid, non-missing	**100.00%**
Consumer ID	100% valid, non-missing	**100.00%**
CPT or HCPC Code	99% present (not zero, blank, 8- or 9-filled). 100% should be valid, State-approved codes. There should be a wide range of procedures with the same frequency as previously encountered.	**100.00%**
Health Care Service Location	95% valid non-missing	**100.00%**
Minutes of Service	100% non-zero; 100% should be valid for the associated CPT Code when present	**87.07%**
Person Identification Code	100% valid, non-missing	**97.84%**
Provider Type	80% valid, non-missing	**99.95%**
Reporting Unit ID	99% present (not zero, blank, 8- or 9-filled). 100% should be valid	**100.00%**
Service Date	100% valid, non-missing; Dates should be evenly distributed across time	**100.00%**
E&T Inpatient Service		
Admission Date (entry present for each episode)	100% valid, non-missing	**100.00%**
Discharge Date	100% valid, non-missing	**100.00%**
Admit Discharge Correspondence	100% of admits and discharges match across all episodes of E&T care	**100.00%**
Consumer Demographics		
Given Name	>85% present	**100.00%**
Surname	>85% present	**100.00%**
Gender	< 2% missing or invalid	**100.00%**
Date of Birth	< 2% missing or invalid	**99.99%**
Race	< 2% missing or invalid	**98.02%**
Ethnicity	< 2% missing or invalid	**100.00%**
Hispanic Origin	< 2% missing or invalid	**100.00%**
Preferred Language	< 2% missing or invalid	**100.00%**
Social Security Number	80% present	**95.01%**

The table to the right is the master legend for any of the following charts that detail the individual PIHPs.

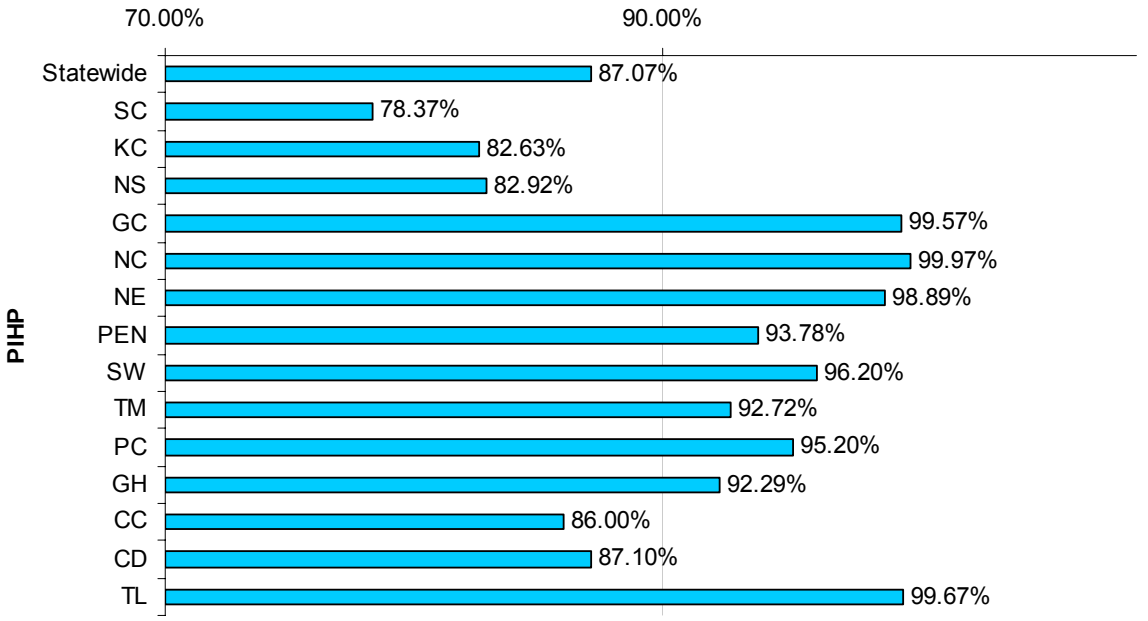
The data is not sorted but follows the order of the RUID (Reporting Unit ID).

RUID	Label	Name
410	SC	Spokane County
411	KC	King County
412	NS	North Sound
413	GC	Greater Columbia
414	NC	North Cental
415	NE	Northeast
416	PEN	Peninsula
417	SW	Southwest
418	TM	Thurston-Mason
419	PC	Pierce County
420	GH	Grays Harbor
424	CC	Clark County
425	CD	Chelan-Douglas
426	TL	Timberlands

Additional Measurements

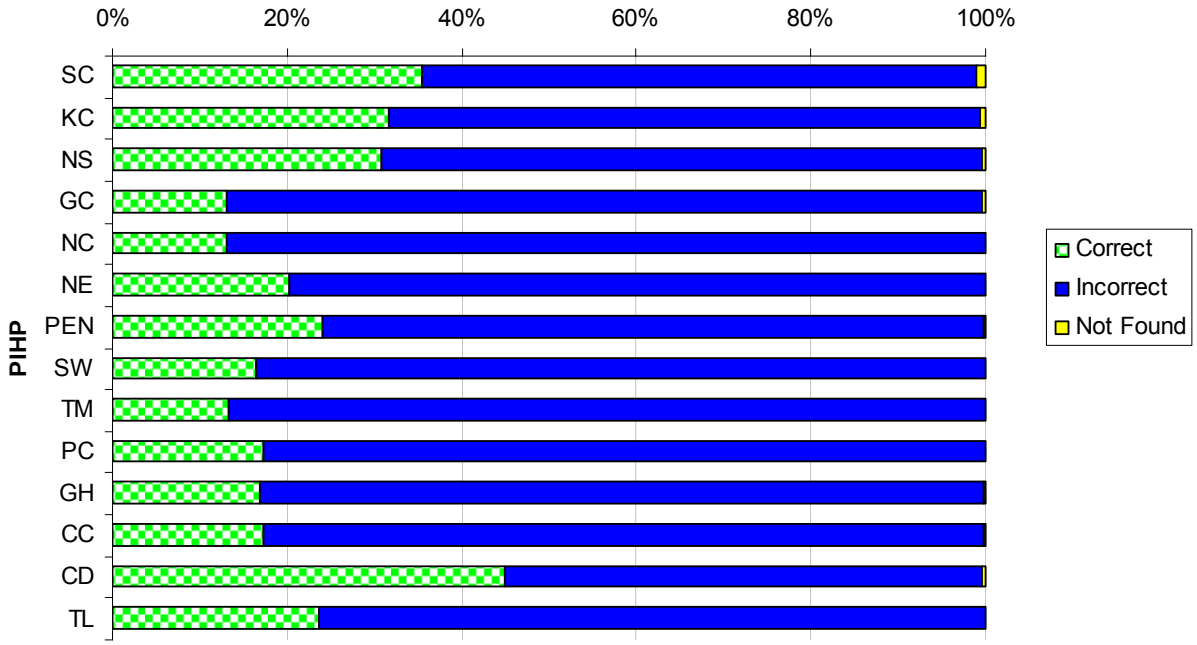
The **Minutes of Service** listed above represents the number present and non-zero. The table below details the individual PIHP results for the completeness of the item. This measure has no value in Phase I without comparing these times to the CPT code for appropriateness; what it shows, is the number of encounters with minutes of service attached to them.

Figure 22: CPT Codes with Minutes of Service



The second Minutes of Service standard required measurement of another aspect, appropriateness of the time related to the CPT or HCPC code. The chart below provides the results of that study.

Figure 23: Time Appropriate for CPT



Due to complexity of the above chart, data related to it is set forth in the following table.

Figure 24: Time Appropriate for CPT or HCPC Code

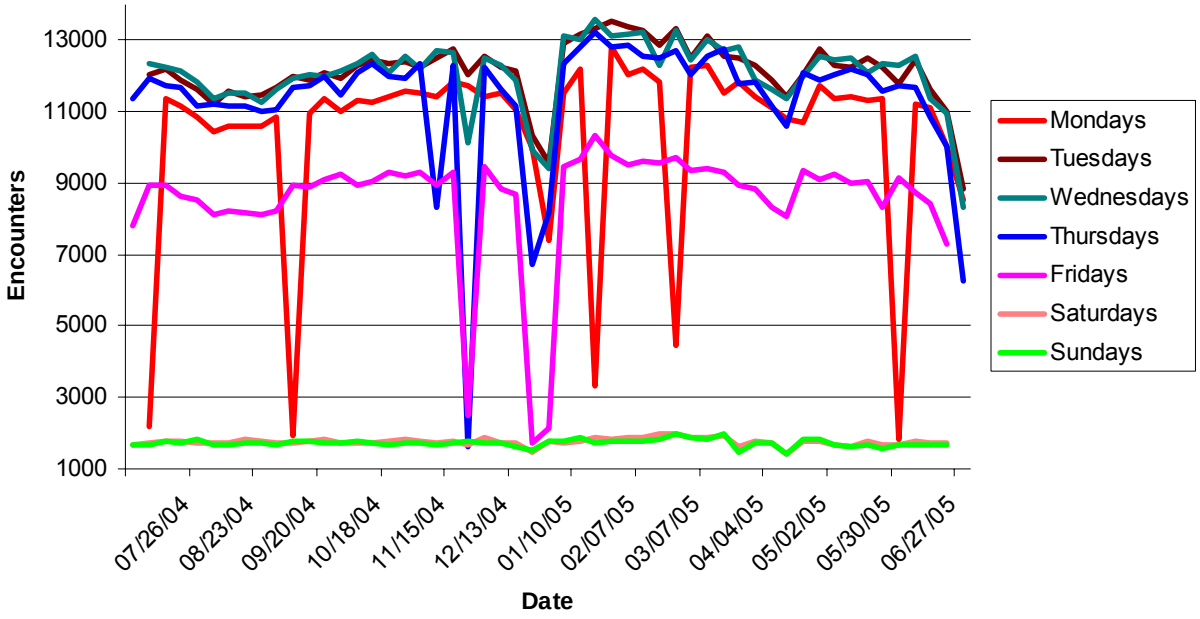
PIHP	Correct		Incorrect		Not Found	
Statewide	806542	26.67%	2203671	72.87%	13825	0.46%
Spokane County	122338	35.52%	218207	63.36%	3867	1.12%
King County	370328	31.69%	791650	67.74%	6743	0.58%
North Sound	87575	30.85%	195141	68.74%	1153	0.41%
Greater Columbia	38279	13.14%	251759	86.41%	1310	0.45%
North Central	1993	13.10%	13221	86.90%	0	0.00%
Northeast Washington	3872	20.28%	15209	79.65%	14	0.07%
Peninsula	38689	23.95%	122694	75.94%	186	0.12%
Southwest	12411	16.41%	63225	83.58%	14	0.02%
Thurston-Mason	11837	13.25%	77494	86.75%	0	0.00%
Pierce County	50459	17.32%	240856	82.68%	0	0.00%
Grays Harbor	4750	16.88%	23361	82.99%	37	0.13%
Clark County	24908	17.33%	118584	82.50%	239	0.17%
Chelan-Douglas	26808	44.95%	32568	54.61%	261	0.44%
Timberlands	12295	23.65%	39702	76.35%	1	0.00%

Note: While the relationship between CPT code and time usage is critical in a fee-for-service

environment, the WAEQRO understands the system in Washington State is not based on fee-for-service. However, maintaining discipline when using CPT codes and associated times enhances the usefulness of the data for management or study purposes. For this reason, the WAEQRO recommends adherence to proper CPT coding conventions in relation to the usage of time.

The **Service Date** standard requires a view of statewide service dates distributed across time. The following chart depicts this view. The following chart cannot be effectively understood in black and white; therefore, a chart depicting each day of the week may be found in the Appendices (see **Appendix 2 – Time Study**).

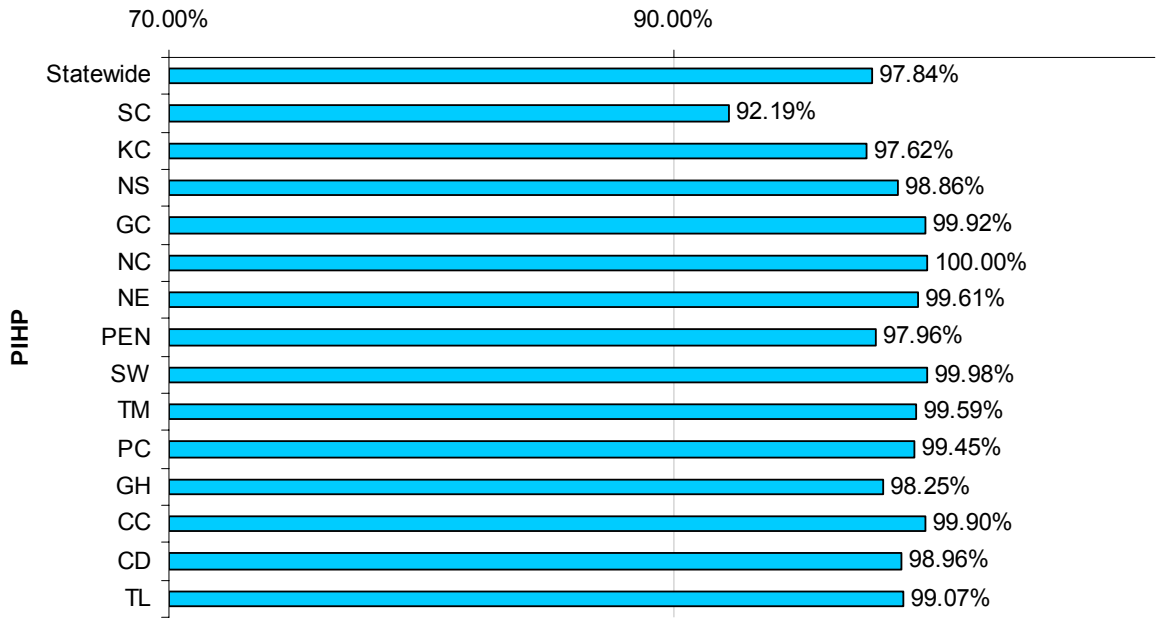
Figure 25: Encounter Distribution by Day of Week



Dips in services can be seen when holidays fall on Mondays and Fridays; this is clearly evident on Thanksgiving and the December holidays. At the bottom of the chart, weekends reflect consistent low levels of activity, averaging roughly 1800 daily encounters.

Person Identification Code: One PIHP met the standard for the Person Identification Code element. Individual PIHP performance is reflected in the chart below.

Figure 26: Person Identification Code



Phase I Notes – Table 1

CPT or HCPC Code, like many items in Phase I, is 100%. A closer examination of the results, the data dictionary definitions, and some ancillary items such as how the system handles errors, reveals that the 100% statewide result is due to the structure of the system and rules for data submission.

The data dictionary states that the CPT code cannot be blank or null and must be correct to be entered into the system. If it is not correct, the transaction is not processed, and a relevant error code is generated. The State's IS does not have a comprehensive system of accountability for encounters not accepted; therefore, it is impossible to ascertain if the item is 100% complete or only 100% correct.

Health Care Service Location is also blocked if a non-valid, null or blank code is submitted. This is the same issue as above: is it 100% complete or 100% correct?

Provider Type is also blocked if it is non-valid. An error message is issued if left blank. This process would account for a higher statewide completeness percentage as well as for the validity of the codes.

For **Emergency and Treatment** (**E&T**) **Inpatient Service**, an admission date for each episode was checked, as was a 100% valid, non-missing discharge date. In addition, a third element was checked to ensure a one-to-one correlation between admit and discharge dates. All three checks yielded 100% results.

Reporting Unit ID (Provider Agency or Sub contractor) cannot be found in the State's data dictionary. System acceptance of this item may be of a design similar to those listed above, with rules blocking invalid codes. One client record reviewed in the state's data contained a provider ID assigned to its encounters for a provider in a different PIHP; this indicates that the system may check for codes it recognizes and not necessarily correct for the PIHP submitting the encounter.

Given Name and Surname are blocked if null or void. One hundred percent of those accepted were counted. This data element is also vulnerable to the complete/correct dilemma.

Gender has a default if there is no entry or if an invalid code is entered. This rule ensures this data element is 100% valid and non-missing. The data dictionary states that this unknown default may be included in the male population for the purpose of statistical reporting.

Date of Birth has a rule that triggers a warning if the date format is not correct or if no date is entered. Dates that appear to be in the future are blocked.

Ethnicity is blocked if an unrecognized, null, or blank code is submitted.

Hispanic Origin is blocked if an unrecognized, null, or blank code is submitted.

Preferred Language has no rules listed in the data dictionary, but its uniform completeness is suspect. There may be an undocumented rule or default operating in the background on this item.

The Consumer Periodics section, listed below, displays two sets of results. The first set represents results based on a simple calculation of valid, non-missing data. However, a closer look at the data being measured and at the definitions for many of the items in the data dictionary or elsewhere indicated that there may be defaults or dual definitions resulting in some false readings. The second set of results titled 'Adjusted Completeness", displays results with the suspect data being considered invalid. Examples of the types of problems found are provided in more detail in Phase I Notes below this table. The true results fall somewhere between the two sets listed below.

Figure 27: Phase I – Table 2

Data Element	Data Standard	Statewide
Consumer Periodics		
Employment Status	80% valid, non-missing	100.00%
Education	80% valid, non-missing	100.00%
Grade Level	80% valid, non-missing	100.00%
Living Situation	80% valid, non-missing	100.00%
County of Residence	< 2% missing or invalid	100.00%
Priority Code	> 90% non-missing and valid codes	100.00%
Diagnosis	> 90% non-missing and valid codes (using ICD-9-CM lookup tables)	92.52%
Impairment Kind	> 90% non-missing and valid codes	100.00%
Annual Gross Income	80% valid, non-missing	93.71%
GAF	100% valid, non-missing	100.00%
CGAS	100% valid, non-missing	100.00%
DC03	100% valid, non-missing	100.00%
Consumer Periodics - Adjusted Completeness		Statewide
Employment Status	80% valid, non-missing	93.37%
Education	80% valid, non-missing	95.49%
Grade Level	80% valid, non-missing	87.80%
Living Situation	80% valid, non-missing	97.55%
County of Residence	< 2% missing or invalid	100.00%
Priority Code	> 90% non-missing and valid codes	94.49%
Diagnosis	> 90% non-missing and valid codes (using ICD-9-CM lookup tables)	92.52%
Impairment Kind	> 90% non-missing and valid codes	100.00%
Annual Gross Income	80% valid, non-missing	93.71%
GAF	100% valid, non-missing	94.23%
CGAS	100% valid, non-missing	79.94%
DC03	100% valid, non-missing	67.94%

Phase I Notes – Table 2

Employment Status has a default value that means either unknown or not reported.

Education, if left blank or null, is set to a code that indicates unknown. If an unrecognized entry is encountered, the transaction is rejected.

Grade Level has a default that means either unknown, never attended, or below pre-school. Assigning multiple definitions to a default should be avoided as the true meaning is lost.

Living Situation, if left blank or null, is set to a code that indicates unknown. If an unrecognized entry is encountered, the transaction is rejected.

Priority Code has one code defined as "other". This may be a default. Although rules are not specified in the data dictionary defining it as such, the high completion rate is suspect.

Diagnosis Code: One PIHP had no diagnosis codes. The WAEQRO understands that, since implementation of the HIPAA rules in 2004, there is no longer a requirement to submit the diagnosis with this data set. The Health Insurance Portability and Accountability Act (HIPAA) includes standard transaction sets in the rules. One of the standard transactions is the 837p (the Health Care Claim – Professional). HIPAA rules require that the diagnosis be submitted with the 837p.

Annual Gross Income had no default definition but is undermined by allowing free form data entry. It therefore becomes difficult to know whether "valid" refers to a particular format or to a dollar value range. Entries statewide on the item ranged from $0 and $1 to over $800,000. There is no way of knowing if these are real values or just noise. While it is more plausible to see the lower than the higher amounts (considering Medicaid eligibility standards), the presence of both undermines confidence in all entries. Three PIHPs fell below the standard for Annual Gross Income.

PIHP 1	68.29%
PIHP 2	76.26%
PIHP 3	71.51%

GAF, CGAS and DC03 all have values to indicate there is not enough information to make a judgment on functional level. When these values are permitted to be used as defaults or placeholders, it is impossible to know whether they represent an inability to assign a proper functional level or if a proper level has not been yet been assigned. The difference in meaning is significant.

For all items in the **Consumer Periodics** section (detailed above, starting with Education Status) a second set of calculations was made removing the suspected defaults. There is a significant difference between the two sets; reality falls somewhere in between.

All of the issues outlined above make it difficult to ascertain with any certainty the true results of the encounter validation. Achieving results that equal 100% is admirable, but highly unlikely. Problems found with the data further erode confidence in the data. There is a high probability that the data being studied reflects 100% of the data that was accepted into the State's database and possibly does not account for data returned due to errors.

Phase II: Data – Clinical Record Comparison

Phase II involved matching clinical records to the data. Two sets of records were collected. The set collected prior to the site visits is referred to as the A-side and the set collected during the site visits as the B-side.

For the A-side, records from 30 randomly selected consumers per PIHP (418 records statewide), containing 12,300 encounters for FY 05, were selected. This number of encounters far exceeds the 411 per PIHP (5754 statewide) needed to draw statistical inference between the data studied and the state of the unstudied data for this PIHP.

For the B-side, 5 records were collected from each of the two providers that participated in the visit during each PIHP visit (except one PIHP, where we only visited one Provider Agency). Those 135 records produced a total of 5897 encounters for the statewide B-side comparison effort. The B-side requires that a minimum of 411 encounters be collected statewide. That goal was exceeded by a large margin. It is important to note that the B-side was not designed to produce individual PIHP statistically relevant results; therefore, PIHP B-side results are not presented in this report. Some comparisons to this set can be helpful, however, in analyzing the results of the A-side (see, **Phase II Results** in Appendix 6).

The table below displays the statewide results of the Phase II Encounter Validation. The statewide column includes all 14 PIHPs plus the B-side results (essentially, 15 PIHPs). The data elements are those assumed to be present in both the clinical record and in the State's dataset that would define an encounter for matching purposes.

Figure 28: Phase II

Encounter Validation Phase II		
Data Element	**Data Standard**	**Statewide**
Outpatient Service		
Reporting Unit ID *(Contractor ID or RSN ID)*	100% valid, non-missing	**21.17%**
Consumer ID	100% valid, non-missing	**60.85%**
CPT or HCPC Code	99% present (not zero, blank, 8- or 9-filled). 100% should be valid, State-approved codes. There should be a wide range of procedures with the same frequency as previously encountered.	**57.74%**
Minutes of Service	100% non-zero; 100% should be valid for the associated CPT Code when present	**83.15%**
Reporting Unit ID (Provider Agency or Subcontractor)	99% present (not zero, blank, 8- or 9-filled). 100% should be valid	**37.04%**
Service Date	100% valid, non-missing; Dates should be evenly distributed across time	**83.15%**
Encounter Matches		**83.15%**

Phase II Encounter Matching Implications

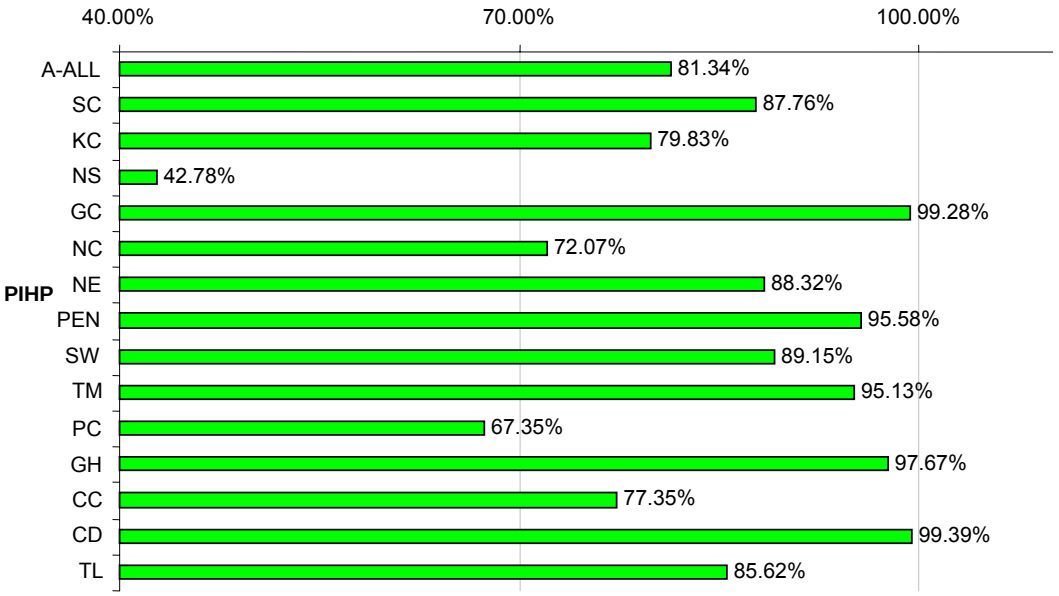
Because Phase II consists of comparison of administrative datasets to data in consumer clinical records, a system of matching must be employed, because only when a match has been achieved, can a comparison be made.

Ideally, the Consumer ID, CPT Code, Date of Service, and Minutes of Service would have been used for this match. However, many records did not include the State Consumer ID, and use of State-approved CPT codes was spotty; accordingly, both were eliminated from the list. Client demographic information (surname, given name, date of birth, and Social Security Number [SSN]) was used to match the individual to the Client ID. The Date of Service and Minutes of Service were then used to evaluate the encounter match. Based on this methodology, Encounter Match percentages are the same as the Minutes of Service and Date of Service match percentages

It is not only important to understand why the Encounter Match is the same as Minutes of Service and Date of Service results, but also that the other results in Phase II are a subset of those matched percentages rather than of the whole universe of encounters. For example, if PIHP X had a 75% encounter match rate, a result of 50% for Client ID would be 50% of the 75%, not of 100% (37.5% of Client IDs would have been matched). The results of both of the Reporting Unit IDs, the Consumer ID, and the CPT or HCPC Code items are percentages of the Encounter Matches, not percentages of either the State's administrative dataset or the total data present in the consumers' records.

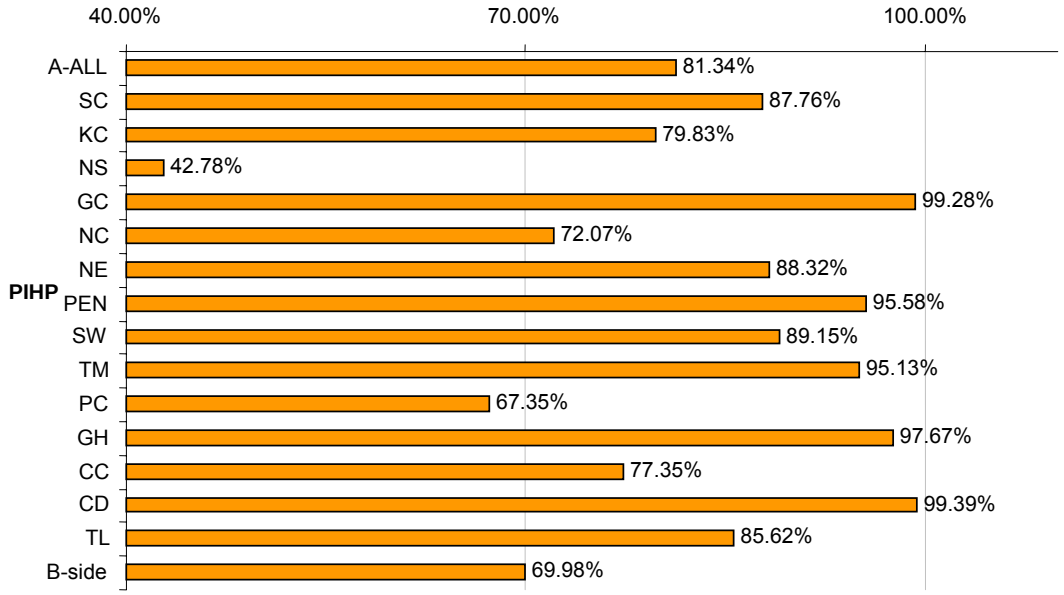
Phase II Notes

Figure 29: A-Side Encounter Matches



Minutes of Service (below) has a standard of 100% non-zero; 100% should be valid for the associated CPT code when present.

Figure 30: Minutes of Service



Please note: the Time-CPT Correlation study yielded a statewide average of only 26.67% correct Minutes of Service entries related to the CPT or HCPC code definitions.

Figure 31: Service Date

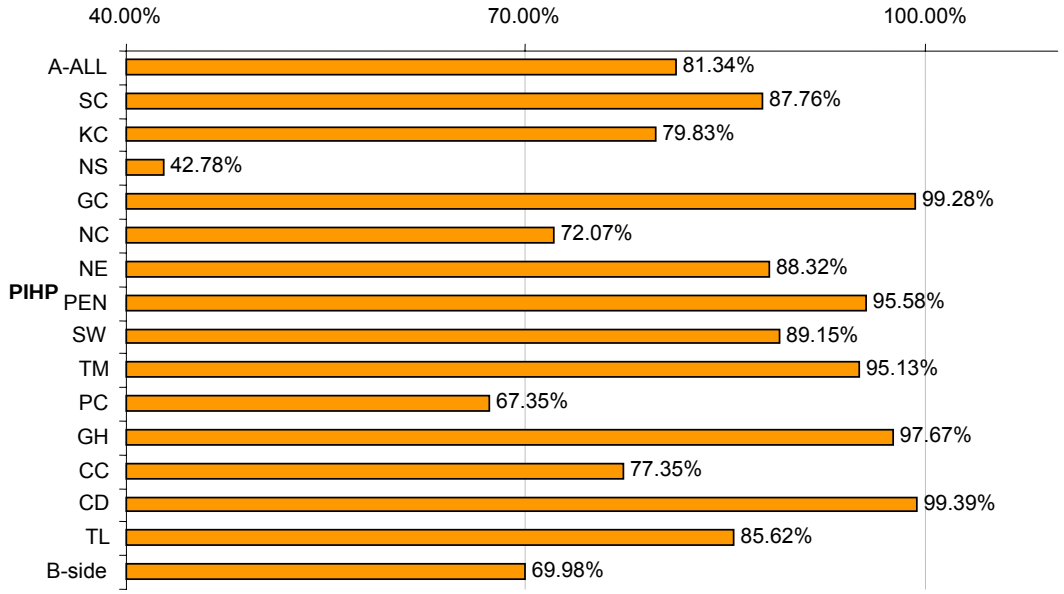
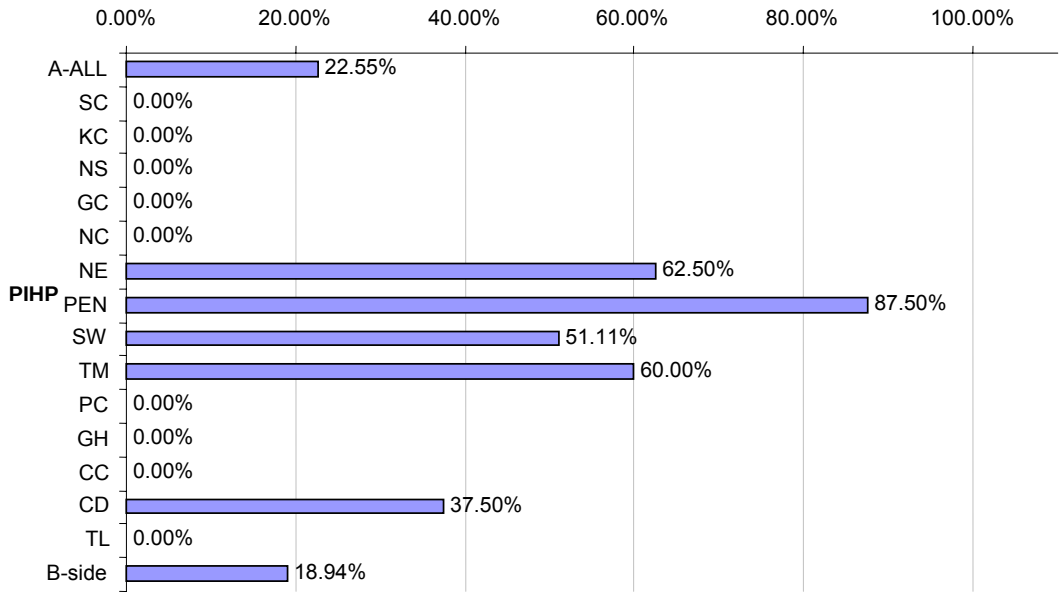
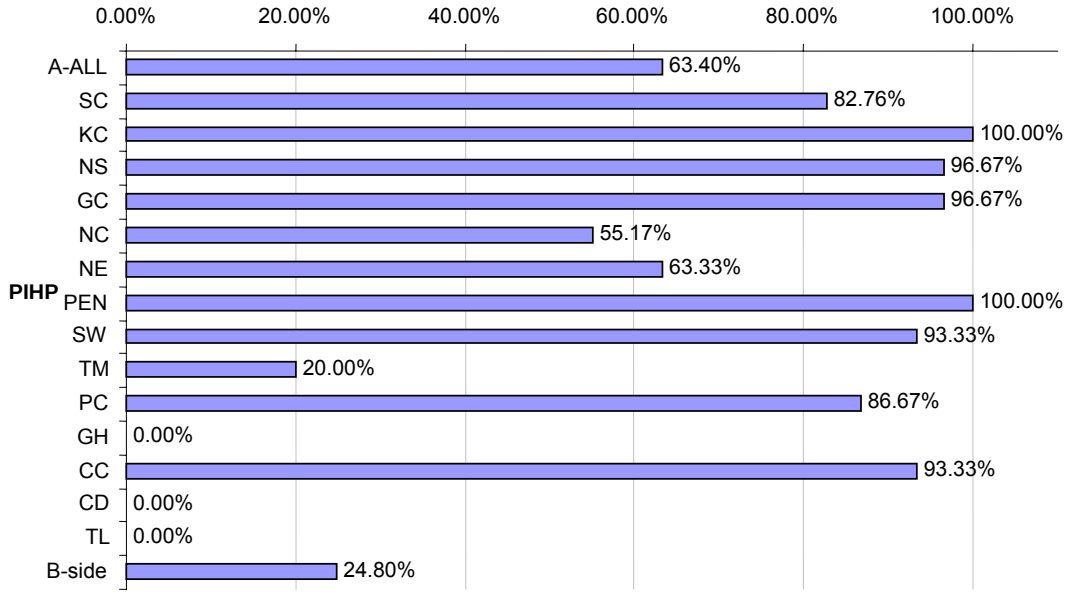


Figure 32: Reporting Unit ID (Contractor ID or RSN ID)



Reporting Unit ID: It is not currently a statewide requirement for this data element to be on the record; therefore, these results are not unexpected. While entitles that use a true electronic medical record can create a query to bring these elements together, such results were generally not part of a consumer's clinical record.

Figure 33: Consumer ID



Consumer ID: Again, the assumption is made that the State Consumer ID is used on the clinical record. Many PIHPs or Provider Agencies use their own local numbering conventions; for such entities, the Consumer ID sought by the State is not in the consumer record. A process is used by the PIHPs to convert these records to the State-issued Consumer ID prior to submitting their data. PIHPs or Provider Agencies who use an electronic medical record vary in how they assign consumer IDs. Some use the State-assigned ID or have it available as an alternative method of identification.

The RUID in combination with the Consumer ID is the 'key' to positively identifying a consumer within the State's database. Without the ability to match the RUID and Consumer ID on the clinical record to the electronic data, the WAEQRO required another method to ensure that records being examined were the ones requested. As previously stated, part of the WAEQRO data request was that a copy of the demographic cover sheet for the individual be sent with the encounter data. WAEQRO used the full name, date of birth, and SSN on the cover sheet to ensure that records matched the requested client.

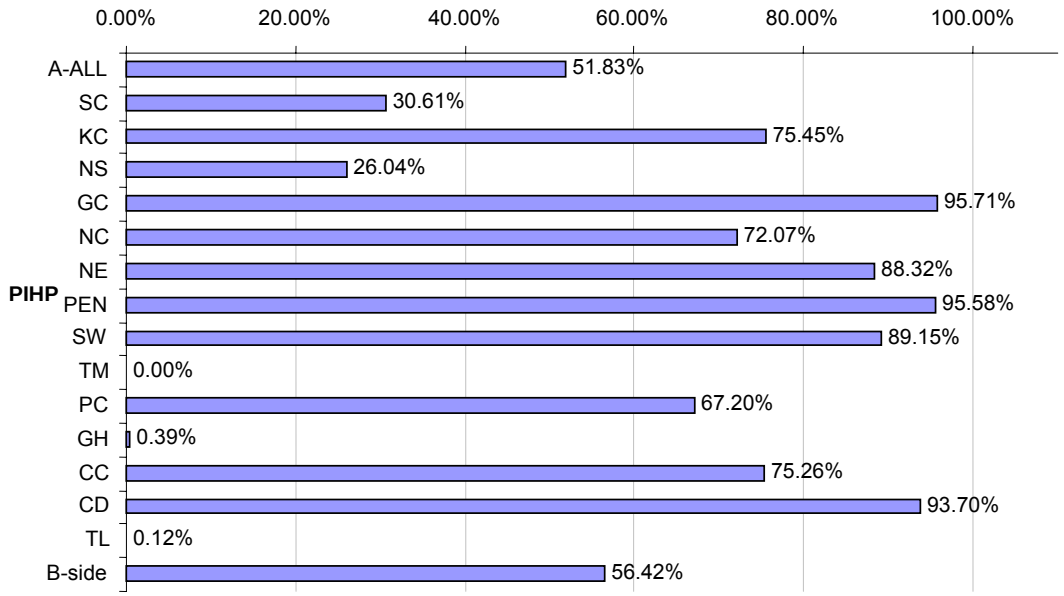
CPT or HCPC Code: The assumption is made that the State-approved codes are those used at the provider level. In practice, however, the codes that are used vary as follows.

- Each Provider Agency within a given network could use their own version of codes, then crosswalk them to the State-approved codes before submission to the PIHP.
- Some PIHPs convert the code to the State-approved codes before submitting data to the State.
- The PIHP could employ a standard set of codes that includes both State-approved codes and special codes requested by Provider Agencies for their own data-reporting purposes. In such cases, the PIHP then uses a crosswalk to convert those special codes to the State-approved codes prior to submission to the State.
- Some PIHPs simply use the State-approved codes.

Only some of the encounters submitted contained the State-approved codes; some had other codes that are mapped to the State codes, and some submitted no information to enable WAEQRO to check the code submitted.

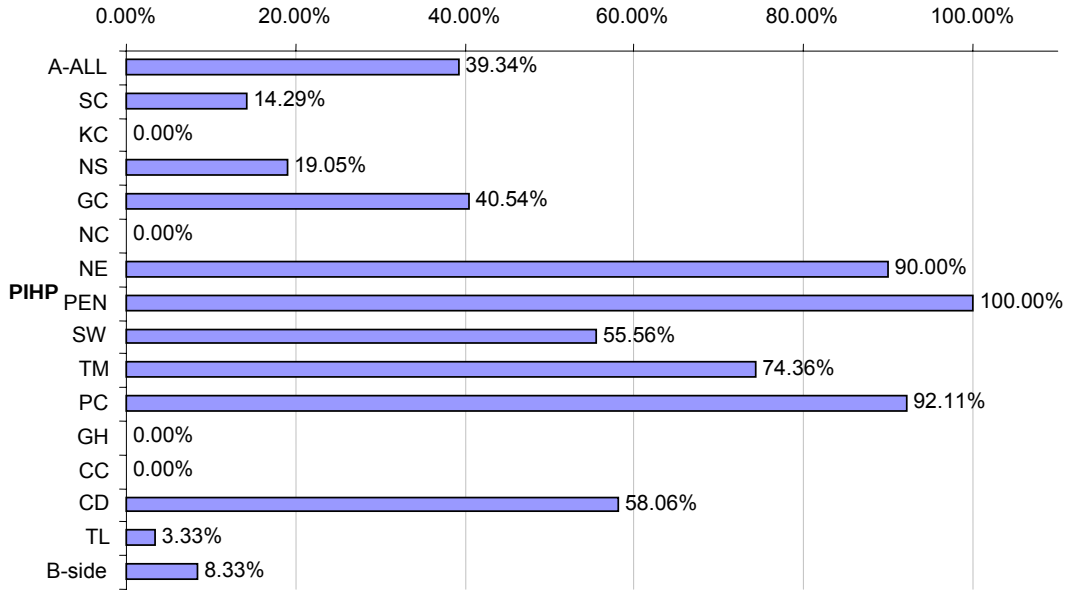
The following chart displays the wide variability that matches the various scenarios outlined above.

Figure 34: CPT or HCPC Code



Reporting Unit ID (Provider ID), in most cases, is not on the consumer record. Instead, the name of a provider agency might be indicated on the encounter form or on the demographic cover sheet (a few Provider IDs were on the demographic cover sheets). Those with electronic medical records can print this code on the record; generally, however, it is not on the record.

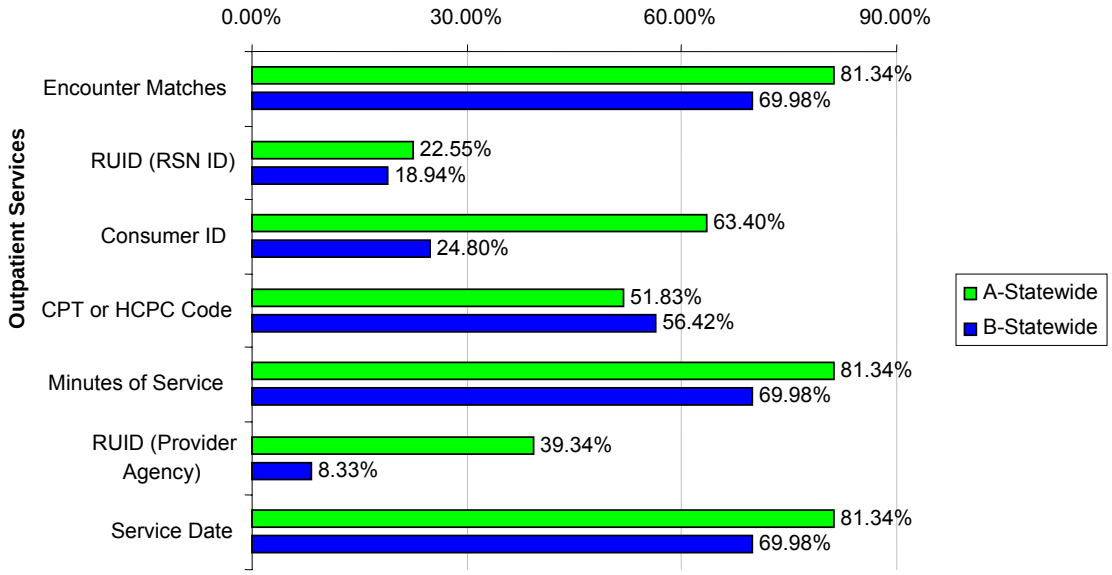
Figure 35: Reporting Unit ID (Provider Agency or Subcontractor)



Phase II Summary Findings

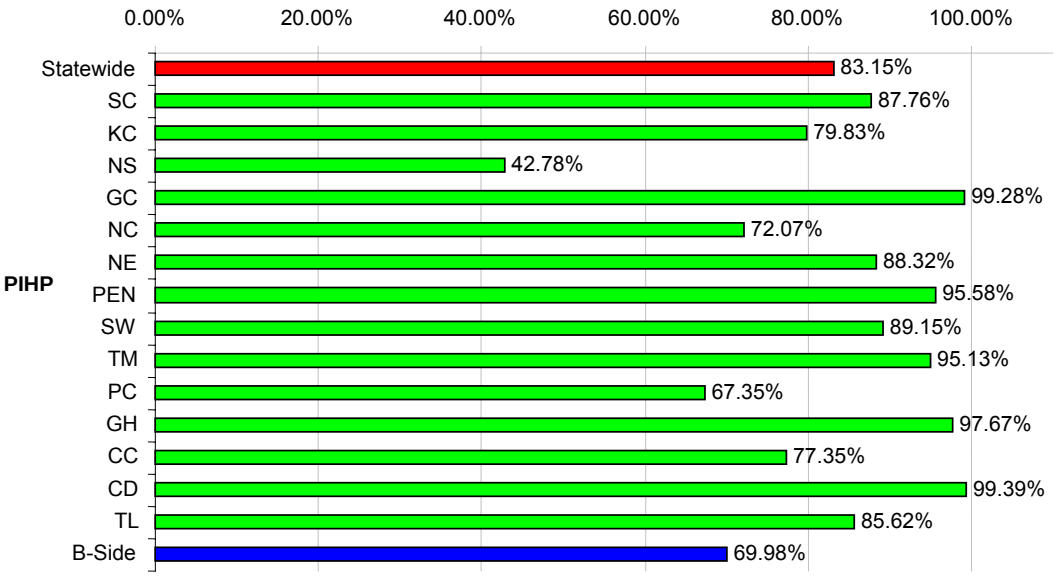
The main objective of Phase II was the validation of encounters. The charts below display the bottom line results of that effort.

Figure 36: A-Side & B-Side



The B-Side is averaged into totals from the PIHPs as if it were itself a PIHP measure. The statewide average (in red/top bar below) was then calculated from those 15 averages.

Figure 38: Statewide Encounter Matches



Encounter Validation Summary

Phase I

The Phase I standards appear reasonable and logical, but a closer look reveals a need for further refinement. A basic check for completeness and data validity gives the appearance that all is in order. Deeper analysis, however, exposes problems. Following is a description, by topic, of the specific problems and examples of the consequences.

Error Processing

Many data elements generate errors when not correctly submitted. The system rejects the encounter, then waits for offending data to be corrected and resubmitted. A result of 100% completeness in fields with filters that do not allow submission of incorrect data can lead to a false assumption that all data is present and correct. However, such might be the case simply because the system does not accept incorrect data.

For example, if an encounter were submitted with an incorrect CPT code, the system generates an error and kicks back the encounter to the submitting PIHP. Presently, the State has no mechanism for tracking these errors, so the system cannot check to ensure that a submission made in error was corrected. PIHPs are expected to have processes to track errors and ensure that data is corrected and resubmitted; and, most do. But what happens if data fails to make it back into the system? The encounter may never be submitted, and no one would know. The lesson to learn here is that error messages and not accepting data submitted in error may give a superficial appearance of reliability; however, a method is needed for tracking transactions to ensure that all errors are resubmitted. This type of accountability should be found at all levels of the data submission process.

Problematic System Defaults

The use of defaults can also cause problems. For example, the WAEQRO's understanding is that there are occasional defaults in the data submission process at levels below MHD. However, little, if any, control exists over these defaults, and they have a way of corrupting data meaning. Most of these unpublished defaults purport to ease the task of data entry. One unconfirmed example from a reliable source is that instead of using the number "3" to designate unknown gender, all unknown genders are defaulted to male. True or not, this illustrates the issue. Certainly, finding unknown gender entries makes it difficult to properly analyze data; this default solution (if it is indeed the process), however, makes the situation even worse.

Another example: in the Consumer Periodic section, the function items appear to have certain defaults. As illustration, a "zero" in all three functional level designations (GAF, CGAS, DC03) indicates insufficient information to make an assessment. When found in the same individual's record over time, it is obviously being used as a default and is not being updated properly; this begins to corrupt the data. One can reasonably ask whether

these are incomplete fields with defaults entered, or whether this many individuals cannot be evaluated to the extent of ascertaining an accurate functioning level.

The same difficulty follows for almost all items in the consumer demographic section. Some items have values that should be entered for "unknown." At education level, for example, a "zero" indicates unknown. This is perfectly acceptable, but "zero" also indicates "no education" and "too young to be in school." When analyzing the data, the questions are obvious. To the fullest extent possible, there should never be multiple meanings for any entry.

Free Form vs. List-defined Data Entry

Allowing free form data entry for information critical to reporting purposes creates the possibility of accidental or purposeful errors that negatively impact reliability of the dataset.

For example, in the item, Annual Gross Income, there are values from $0 and $1 all the way to something approaching a million. Therefore, WAEQRO was unable to ascertain the validity of this data element. Since it is important to have accurate information about income, both for Medicaid eligibility and outcome/performance reporting, this item would have far greater value if it offered standard selection ranges. The system then could define the limits of the reporting and be better assured that the data is valid and reliable.

Ambiguous Data Dictionary/Standards Definitions

With the CPT or HCPC Codes, the system had entries not listed as valid in the list of State-approved codes. In fact, some are actually annotated with the remark, "not a state-approved modality." The code remains in the system; yet, the Data Dictionary states that invalid codes are not accepted into the system. If an invalid code is submitted, a specific error is issued and the encounter is "kicked back" to the submitting PIHP. The WAEQRO made the assumption that if a code was in the system, it was a State-approved code. The system rules force the same result as is found in the description of Data Completeness in the Error Processing section above.

Many of the CPT or HCPC codes were submitted with invalid times (minutes of service). The system should reject codes accompanied by invalid minutes of service; however, there is no procedure to accomplish this. The result is that when attempting to measure data validity for this element (see Phase I CPT Code Completeness and Validity), without factoring in the time entered, true validity of the CPT code could not be ascertained. The standard should be corrected to include the minutes of service as a factor when ascertaining validity of the CPT codes.

Phase II

The Phase II validation yielded some disappointing results. Some of the problems related to the standards and expectations. The most significant of these relates to client record content. There appear to be as many ways to create a client record as there are provider agencies. Some elements are fairly consistent; many are not. It appears that the expectation for specific data elements in the client chart was not communicated to the

provider agencies. Therefore, expecting that data would be available for an encounter validation was unrealistic.

Encounter Validation Recommendations

The WAEQRO recommends that the results of this encounter validation be used as a map to address the many inconsistencies found in the field. Item by item, the cause of the problem needs to be identified, with efforts then made to design solutions. A work group should be assembled from the PIHPs; the most appropriate participants would be from the Performance Data Group. It would be helpful if the WAEQRO were represented at these meetings to ensure that the group understands the problem, as well as consequences of the current procedures.

APS recommends that the following specific issues be prioritized:

1. If used, data defaults should be extremely finite. If at all possible, avoid assigning a single code for multiple purposes.

2. Identify and eliminate undocumented defaulting by the PIHPs or Provider agencies.

3. Mandate record structures and components where needed.

4. Use drop-downs in the database instead of fill-in fields for items such as annual gross income. Select a range and limit that range to reasonable and realistic values.

5. Create a system of accountability for errors. Force the system to address uncorrected errors or system-defaults that appear to have been overlooked or set aside.

In addition, WAEQRO advises that mini-record audits be modeled after the encounter validation. The parts and pieces of the validation can be divided into smaller studies for economical review; these “mini” encounter validations will help prepare the environment for the full-sized encounter validations.

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Appendices

Appendix 1C - 2005 Score Distribution across PIHP - Subpart C

Appendix 1D - 2005 Score Distribution across PIHP - Subpart D

Appendix 1F - 2005 Score Distribution across PIHP - Subpart F

Appendix 1H - 2005 Score Distribution across PIHP - Subpart H

Appendix 2 - Time Study

Appendix 3 - Phase I EV Chart

Appendix 4C - 2004 Score Table with Weighted Average - Subpart C

Appendix 4D - 2004 Score Table with Weighted Average - Subpart D

Appendix 4F - 2004 Score Table with Weighted Average - Subpart F

Appendix 4H - 2004 Score Table with Weighted Average - Subpart H

Appendix 5 - MHD EV Data Standards

Appendix 6 - Phase II EV Chart

Appendix 7C - 2005 Score Distribution across PIHP - Subpart C

Appendix 7D - 2005 Score Distribution across PIHP - Subpart D

Appendix 7F - 2005 Score Distribution across PIHP - Subpart F

Appendix 7H - 2005 Score Distribution across PIHP - Subpart H

2005 Score Table with Enrollment-Weighted Statewide Averages - Subpart C

<< Shading indicates 2004 Corrective Action Item
text << Underlining indicates 2004 EQRO improvement recommendation

Item		King	Greater Columbia	North Sound	Pierce	Spokane	Clark	Peninsula	Thurston Mason	North Central	Southwest	Timberlands	Chelan-Douglas	Northeast	Grays Harbor	WA State Simple Average	WA State Weighted Average	Strength Stars Q(s1)	Strength Stars Q(s2)	Strength Stars Stars	Weakness Flags Q(w1)	Weakness Flags Q(w2)	Weakness Flags Flags
																		Is State Wtd Average at least 3.7?	Did more than 9 PIHPs score at least 3.7?	Items satis-fying both Q(s1) & Q(s2)	Is State Wtd Average less than 3?	Did more than 7 PIHPs score under 3?	Items satis-fying both Q(w1) & Q(w2)
	Weighting Factor: Enrollment (1,000s)*	216	151	147	121	88	65	47	42	41	21	21	21	17	16			3.7	9	0 stars	3.0	7	0 flags
Q01	Accessible written information requirement	4	4	3	4	3	4	1	4	1	4	3	2	3	1	2.9	3.4						
Q02	Policy guaranteeing enrollee rights	3	2	4	3	4	4	2	3	3	4	4	3	3	3	3.2	3.1						
Q03	Subcontracts require advising enrollees of	3	4	4	4	4	3	3	4	2	4	4	2	4	3	3.4	3.5						
Q04	Subcontractors publicly post rights in req la	3	2	3	4	2	3	3	3	1	5	4	2	1	3	2.8	2.8				•		
Q05	Subcontractors assure client rights underst	4	3	4	3	4	4	3	5	4	3	4	1	3	3	3.4	3.6						
Q06	Subcontractors protect exercising of client	5	3	3	3	3	3	4	3	3	3	3	1	3	4	3.1	3.4						
Q07	Policy re: other Federal/State law complian	3	1	3	3	4	3	1	3	3	2	4	4	4	4	3.0	2.8				•		
Q08	Subcontracts include Federal/State law cor	4	3	3	5	5	3	2	3	4	4	3	4	4	4	3.6	3.7						
Q09	Policies ensure specific rights compliance	2	1	3	4	3	3	4	2	3	3	2	3	3	3	2.8	2.6				•		
Q10	Subcontracts reference specific rights com	3	2	5	3	3	4	4	3	3	3	4	2	3	2	3.1	3.2						
Q11	PIHP monitors provider compliance with la	3	3	4	5	1	3	2	4	2	3	3	1	1	2	2.6	3.1						
Q12	PIHP P&P against prohibitions re: advising	4	3	3	5	3	3	4	3	4	3	4	4	5	3	3.6	3.6						
Q13	Enrollee payment liability protections	1	2	4	3	0	3	3	2	4	3	3	3	3	3	2.6	2.3				•		
Q14	PIHP P&P re: Mental Health Advance Dire	4	3	4	4	1	4	2	4	1	2	4	4	2	4	3.1	3.3						
Q15	Prompt law upadates to MHAD P&P	4	3	4	3	4	3	3	4	3	3	4	4	2	3	3.4	3.5						
Q16	Subcontractors req to have MHAD P&P	3	3	4	4	3	3	4	4	3	3	4	3	4	4	3.5	3.4						
Q17	Document clients informed of MHAD & chc	2	2	4	3	1	3	1	3	3	2	4	3	4	4	2.8	2.6				•		

** as of June 2005, calculated April 2006*

2005 Score Table with Enrollment-Weighted Statewide Averages - Subpart D

(shaded) << Shading indicates 2004 Corrective Action Item
text << Underlining indicates 2004 EQRO improvement recommendation

Item		King	Greater Columbia	North Sound	Pierce	Spokane	Clark	Peninsula	Thurston Mason	North Central	Southwest	Timberlands	Chelan-Douglas	Northeast	Grays Harbor	WA State Simple Average	WA State Weighted Average	*Strength Stars* Q(s1) Is State Wtd Average at least 3.7?	Q(s2) Did more than 9 PIHPs score at least 3.7?	Stars Items satis-fying both Q(s1) & Q(s2)	*Weakness Flags* Q(w1) Is State Wtd Average less than 3?	Q(w2) Did more than 7 PIHPs score under 3?	Flags Items satis-fying both Q(w1) & Q(w2)
	Weighting Factor: Enrollment (1,000s)*	216	151	147	121	88	65	47	42	41	21	21	21	17	16			3.7	9	2 stars	3.0	7	12 flags
Q18	PIHP monitors access and service availabi	3	2	4	4	3	3	3	4	3	3	5	4	3	2	3.3	3.2						
Q19	PIHP monitors & reports network sufficienc	3	3	3	3	3	4	3	4	3	3	4	3	3	3	3.2	3.1						
Q20	PIHP manages network adequacy	3	1	3	4	3	3	3	4	3	3	5	3	3	2	3.1	2.9				•		
Q21	Second opinion mechanism	3	3	4	3	3	3	2	2	4	3	5	3	2	2	3.0	3.1						
Q22	PIHP has out-of-network P&P	3	3	4	3	3	3	3	3	3	2	3	2	2	1	2.7	3.1						
Q23	PIHP P&P re: out-of-network payment coo	2	4	4	3	3	3	3	3	3	2	2	3	2	1	2.7	3.0				•		
Q24	PIHP P&P re: out-of-network cost to enroll	2	2	4	3	0	2	4	3	2	2	4	3	3	1	2.5	2.4				•		
Q25	Ensures compliance with timely access sta	4	3	4	4	3	4	4	5	4	4	3	3	4	4	3.8	3.8	•	•	*star*			
Q26	Timely access standards in subcontracts	3	3	3	4	2	4	4	5	4	3	3	3	3	4	3.4	3.3						
Q27	PIHP oversight of provider timely access c	3	3	4	4	1	3	3	5	3	3	4	4	4	2	3.3	3.2						
Q28	Culturally competent services by MH Spec	5	4	2	5	3	5	4	4	3	4	5	3	4	4	3.9	4.0	•	•	*star*			
Q29	Written & oral translation of client materials	2	3	2	4	2	3	2	3	1	3	2	1	4	1	2.4	2.5				•	•	*flag*
Q30	Ensure Interpreter availability	3	3	4	3	2	4	2	3	3	3	3	4	4	3	3.1	3.1						
Q31	Culturally competent subcontractor special	5	4	3	5	3	5	4	4	3	3	3	3	4	4	3.8	4.1	•					
Q32	Written and oral translation by subcontract	2	3	3	3	2	3	3	3	1	2	3	2	2	2	2.4	2.5				•		
Q33	Monitoring of culturally competent services	4	3	3	4	1	4	3	3	3	2	4	2	4	3	3.1	3.2						
Q34	Sufficiency of provider network to meet nee	3	2	3	4	3	2	3	4	3	3	5	2	3	2	3.0	3.0				•		
Q35	Changes in capacity and services reported	3	5	3	4	3	4	3	4	3	3	4	1	3	3	3.3	3.5						
Q39	Consistent authorization standards	4	2	4	4	3	4	3	3	4	3	3	3	2	2	3.1	3.4						
Q40	Authorization conducted by MHPs	1	1	4	2	4	4	3	3	3	3	3	1	3	2	2.6	2.4				•		
Q41	Monitoring of consistent authorization prac	3	0	4	4	3	4	2	3	2	1	3	3	2	2	2.6	2.7				•		
Q42	Adverse action notices meet requirements	1	1	5	4	2	1	2	3	2	1	2	1	1	1	1.9	2.2				•	•	*flag*
Q43	Standard authorization requirements	1	1	5	4	2	4	2	3	2	3	2	1	2	2	2.4	2.5				•	•	*flag*
Q44	Expedited authorization requirements	2	1	2	3	2	4	1	3	2	2	2	3	3	2	2.3	2.1				•	•	*flag*
Q45	Extension of expedited authorization reque	0	1	2	3	2	3	1	3	1	2	2	3	2	2	1.9	1.6				•	•	*flag*
Q47	Protection against provider discrimination	2	0	3	5	2	3	2	3	3	3	3	3	3	4	2.8	2.5				•		
Q48	Policy re: excluded providers	3	3	4	3	2	3	4	4	3	3	5	5	3	3	3.4	3.2						
Q49	Confidentiality compliance	5	5	4	5	4	5	3	5	5	2	5	3	3	3	4.1	4.5	•					
Q50	Privacy compliance by subcontractors	5	3	4	3	3	2	3	5	5	3	5	3	3	3	3.6	3.7	•					
Q51	Privacy compliance subcontractor audits	5	3	4	0	2	3	0	4	1	1	3	3	2	3	2.4	2.9				•		
Q52	Pre-subdelegation evaluation	5	1	2	1	3	3	1	2	2	2	2	2	1	2	2.1	2.5				•	•	*flag*
Q53	Written subdelegation agreement	5	1	3	2	4	4	1	1	1	1	1	2	1	1	2.0	2.7				•	•	*flag*
Q54	Annual subcontractor subdelegation perfor	5	1	3	2	3	4	1	1	1	2	2	2	1	2	2.1	2.7				•	•	*flag*
Q55	Corrective actions re: subdelegation deficie	5	1	5	2	3	4	2	2	2	2	2	2	1	2	2.5	3.1					•	
Q56	Adoption of evidenced based practice guid	4	1	3	3	1	1	2	3	1	1	5	2	2	2	2.2	2.4				•	•	*flag*
Q57	Dissemination of practice guidelines	4	1	3	3	1	2	3	3	1	0	4	2	3	3	2.4	2.5				•		
Q58	Application of practice guidelines	1	0	3	3	1	0	2	3	1	1	4	1	1	2	1.6	1.5				•	•	*flag*
Q60	Performance measurement data submissic	0	5	0	0	0	0	3	3	0	0	0	5	0	4	1.4	1.2				•	•	*flag*
Q61	Detection of over & under utilization	3	4	5	2	3	3	2	4	1	2	3	3	1	2	2.7	3.2						
Q62	Quality care to enrollees with special healt	4	4	4	2	3	5	4	3	3	1	2	2	3	2	3.0	3.5						
Q64	Annual data submission to State	0	5	0	0	0	0	3	3	0	0	0	5	0	4	1.4	1.2				•	•	*flag*

** as of June 2005, calculated April 2006*

2005 Score Table with Enrollment-Weighted Statewide Averages - Subpart F

		<< Shading indicates 2004 Corrective Action Item text << Underlining indicates 2004 EQRO improvement recommendation																Strength Stars			Weakness Flags		
		King	Greater Columbia	North Sound	Pierce	Spokane	Clark	Peninsula	Thurston Mason	North Central	Southwest	Timberlands	Chelan-Douglas	Northeast	Grays Harbor	WA State Simple Average	WA State Weighted Average	Q(s1) Is State Wtd Average at least 3.7?	Q(s2) Did more than 9 PIHPs score at least 3.7?	Stars Items satis-fying both Q(s1) & Q(s2)	Q(w1) Is State Wtd Average less than 3?	Q(w2) Did more than 7 PIHPs score under 3?	Flags Items satis-fying both Q(w1) & Q(w2)
Item	ghting Factor: Enrollment (1,000s)*	**216**	**151**	**147**	**121**	**88**	**65**	**47**	**42**	**41**	**21**	**21**	**21**	**17**	**16**			**3.7**	**9**	**0 stars**	**3.0**	**7**	**1 flags**
Q71	Authority to file grievance	4	3	4	4	4	2	2	2	2	4	3	5	3	2	**3.1**	**3.4**						
Q72	Timing and Procedures for filing	3	3	3	4	3	3	2	2	2	3	3	3	3	1	**2.7**	**3.0**				•		
Q73	Timing of notice	1	1	3	4	3	1	2	3	1	1	2	2	1	2	**1.9**	**2.0**				•	•	***flag***
Q74	Administrative assitance for enrollees	2	4	4	3	1	3	2	3	2	3	3	3	3	2	**2.7**	**2.8**				•		
Q75	Grievance acknowledgement	3	3	3	3	3	3	3	3	2	3	3	1	3	3	**2.8**	**2.9**				•		
Q76	Appropriate grievance review personnel	3	3	3	3	3	3	2	3	2	3	3	3	3	3	**2.9**	**2.9**				•		
Q77	Special requirements for appeals	1	3	5	3	3	3	3	3	2	3	3	2	3	2	**2.8**	**2.8**				•		
Q78	Enrollee access to case file	4	3	3	3	3	3	2	3	4	3	3	2	3	2	**2.9**	**3.2**						
Q79	Included appeal parties	3	3	3	3	3	3	3	2	2	3	3	2	3	2	**2.7**	**2.9**				•		
Q80	Resolution and notification of grievances &	3	3	4	3	3	3	2	3	2	3	3	2	3	2	**2.8**	**3.0**						
Q81	Content of Notice of Appeal Resolution	3	3	4	3	3	3	3	3	4	3	3	4	3	2	**3.1**	**3.2**						
Q82	State fair hearings requirements	3	3	4	3	3	3	2	2	2	3	3	2	2	2	**2.6**	**3.0**				•		
Q83	Expedied appeal resolution/prohibition aga	2	3	3	3	3	3	3	3	2	3	3	3	3	2	**2.8**	**2.7**				•		
Q84	Denial of expedited resolution	3	3	3	3	3	3	3	3	2	3	3	3	3	2	**2.9**	**2.9**				•		
Q85	Use of State developed description in subc	3	3	4	3	3	3	3	3	2	3	3	1	3	3	**2.9**	**3.1**						
Q86	Record keeping	3	4	4	3	3	3	2	3	2	3	1	3	2	2	**2.7**	**3.1**						
Q87	Review and quality improvement	4	4	4	3	3	3	3	3	2	3	2	2	4	3	**3.1**	**3.4**						
Q88	Rights upheld during pended appeal	4	3	2	3	3	3	3	3	1	3	3	4	3	1	**2.8**	**3.0**				•		
Q89	Rights upheld regarding disputed services	3	3	4	3	3	3	3	3	4	3	3	3	3	3	**3.1**	**3.2**						

** as of June 2005, calculated April 2006*

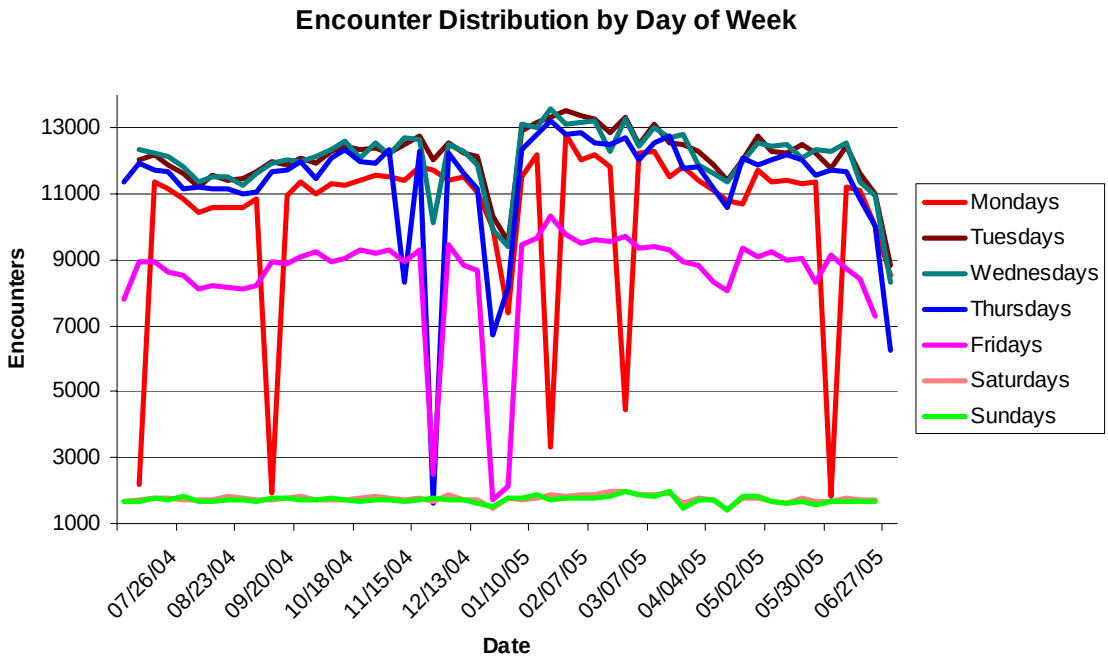
2005 Score Table with Enrollment-Weighted Statewide Averages - Subpart H

		King	Greater Columbia	North Sound	Pierce	Spokane	Clark	Peninsula	Thurston Mason	North Central	Southwest	Timberlands	Chelan-Douglas	Northeast	Grays Harbor	WA State Simple Average	WA State Weighted Average	Strength Stars Q(s1) Is State Wtd Average at least 3?	Strength Stars Q(s2) Did more than 9 PIHPs score at least 3?	Strength Stars Stars Items satis-fying both Q(s1) & Q(s2)	Weakness Flags Q(w1) Is State Wtd Average less than 3?	Weakness Flags Q(w2) Did more than 7 PIHPs score under 3?	Weakness Flags Flags Items satis-fying both Q(w1) & Q(w2)
Item	Weighting Factor: Enrollment (1,000s)*	**216**	**151**	**147**	**121**	**88**	**65**	**47**	**42**	**41**	**21**	**21**	**21**	**17**	**16**			**3.0**	**9**	**3 stars**	**3.0**	**7**	**1 flags**
Q90.a	Source of certification	3	3	3	3	3	3	3	3	0	3	0	3	3	3	**2.6**	**2.8**		•		•		
Q90.b1	Data content certification	3	3	3	3	3	3	3	3	3	3	0	3	3	3	**2.8**	**2.9**		•		•		
Q90.b2	Certification content requirements	3	3	3	3	3	3	3	3	3	3	0	3	3	3	**2.8**	**2.9**		•		•		
Q90.b3	Certification timing	3	3	0	3	3	3	0	3	0	3	0	3	3	3	**2.1**	**2.2**		•		•		
Q91.b1	Written fraud & abuse p&ps/compliance pl	3	3	3	3	3	3	3	3	3	3	3	3	3	3	**3.0**	**3.0**	•	•	***star***			
Q91.b2	Accountable compliance officer/committee	3	3	3	3	3	3	3	3	3	3	3	3	3	3	**3.0**	**3.0**	•	•	***star***			
Q91.b3	Effective Compliance training and educatio	3	3	3	3	3	3	3	3	3	3	3	3	3	0	**2.8**	**3.0**		•		•		
Q91.b4	Effective compliance communication	3	3	0	0	3	3	3	3	3	3	3	0	3	3	**2.4**	**2.1**		•		•		
Q91.b5	Well publicized disciplinary guidelines	3	3	3	3	3	0	3	3	3	3	3	3	3	3	**2.8**	**2.8**		•		•		
Q91.b6	Internal audit provisions	3	3	3	3	3	0	0	0	3	0	0	0	0	0	**1.3**	**2.3**				•	•	***flag***
Q91.b7	Prompt response to offenses	3	3	3	3	3	3	3	3	3	3	3	3	3	3	**3.0**	**3.0**	•	•	***star***			
Q92	Prohibited affiliations with the Federally del	3	3	3	3	3	3	3	3	0	3	3	3	3	3	**2.8**	**2.9**		•		•		

<< Shading indicates 2004 Corrective Action Item

text << Underlining indicates 2004 EQRO improvement recommendation

** as of June 2005, calculated April 2006*


Encounter Distribution by Day of Week
Encounters
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11000
9000
7000
5000
3000
1000
07/26/04
08/23/04
09/20/04
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11/15/04
12/13/04
01/10/05
02/07/05
03/07/05
04/04/05
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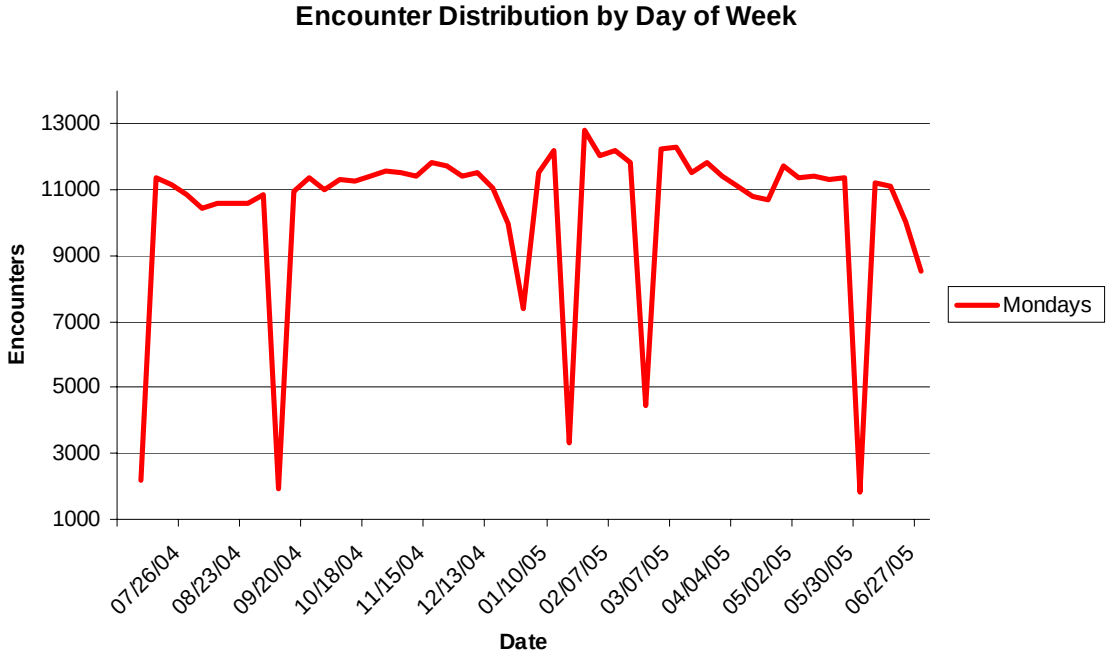
06/27/05
Date
Mondays
Tuesdays
Wednesdays
Thursdays
Fridays
Saturdays
Sundays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07/26/04
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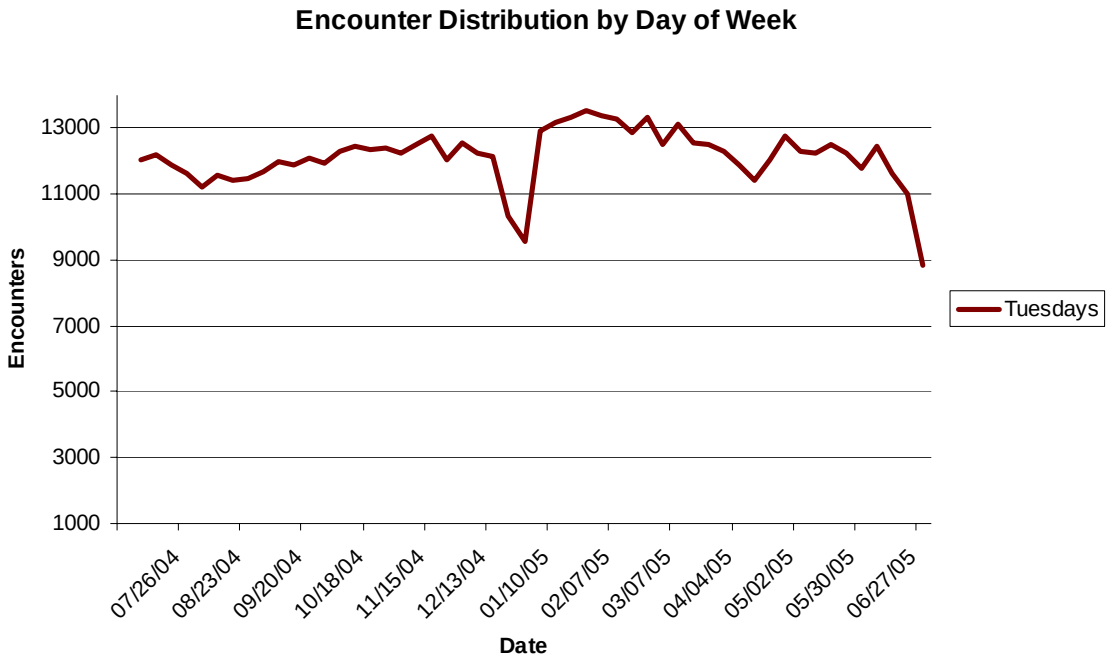
11/15/04
12/13/04
01/10/05
02/07/05
03/07/05
04/04/05
05/02/05
05/30/05
06/27/05
Date
Mondays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Encounters
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07/26/04
08/23/04
09/20/04
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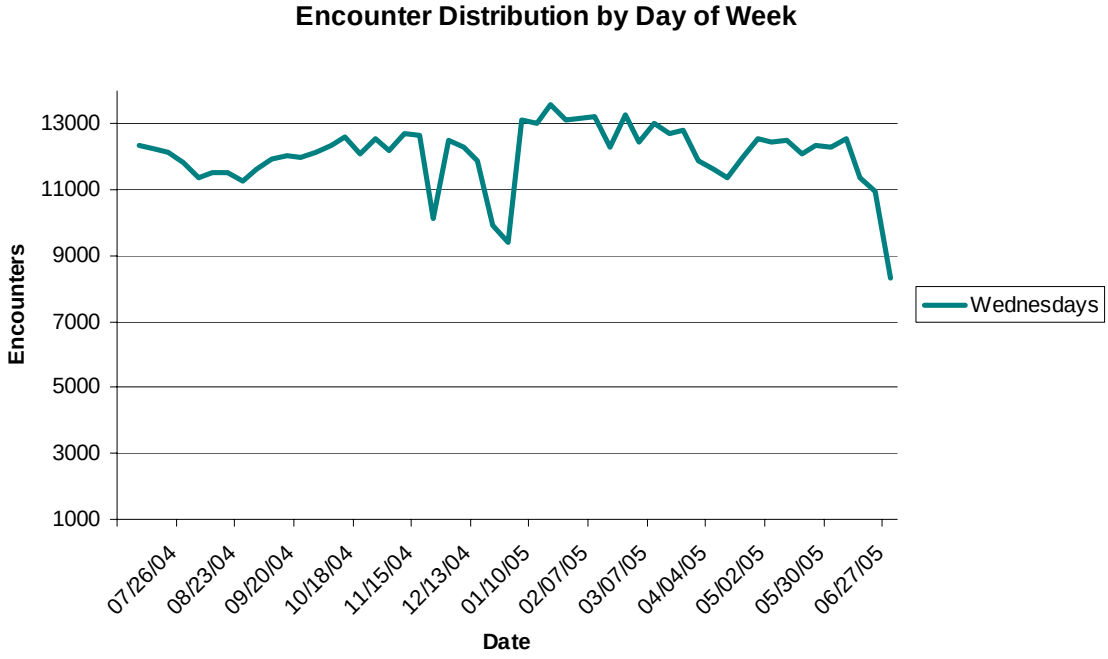
11/15/04
12/13/04
01/10/05
02/07/05
03/07/05
04/04/05
05/02/05
05/30/05
06/27/05
Date
Tuesdays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1000
07/26/04
08/23/04
09/20/04
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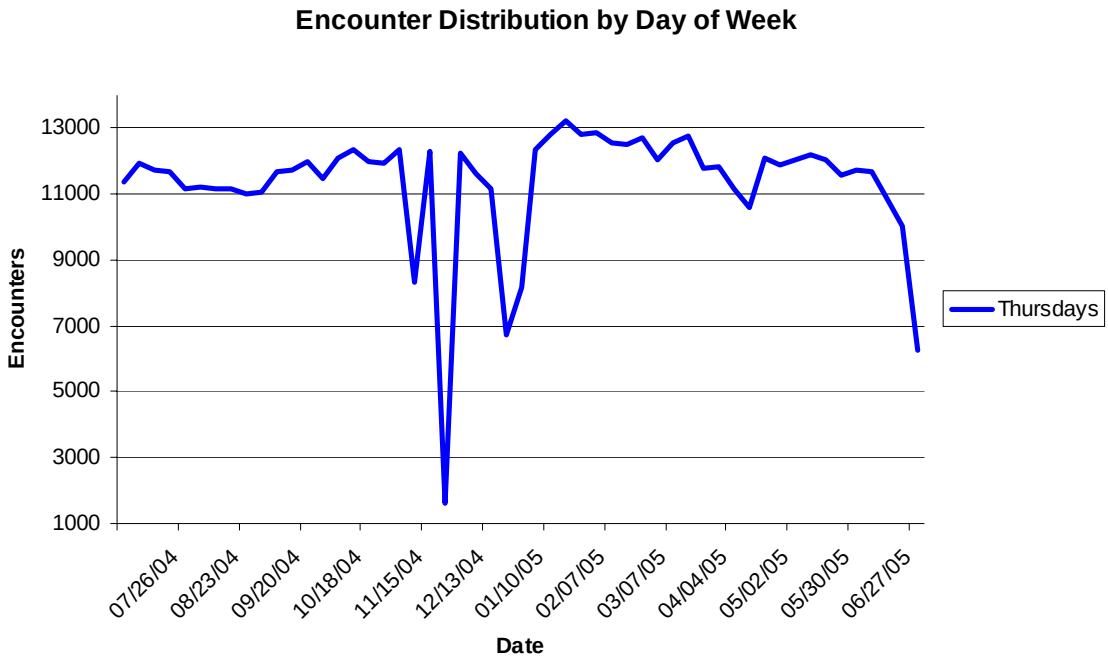
11/15/04
12/13/04
01/10/05
02/07/05
03/07/05
04/04/05
05/02/05
05/30/05
06/27/05
Date
Wednesdays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Encounters
13000
11000
9000
7000
5000
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07/26/04
08/23/04
09/20/04
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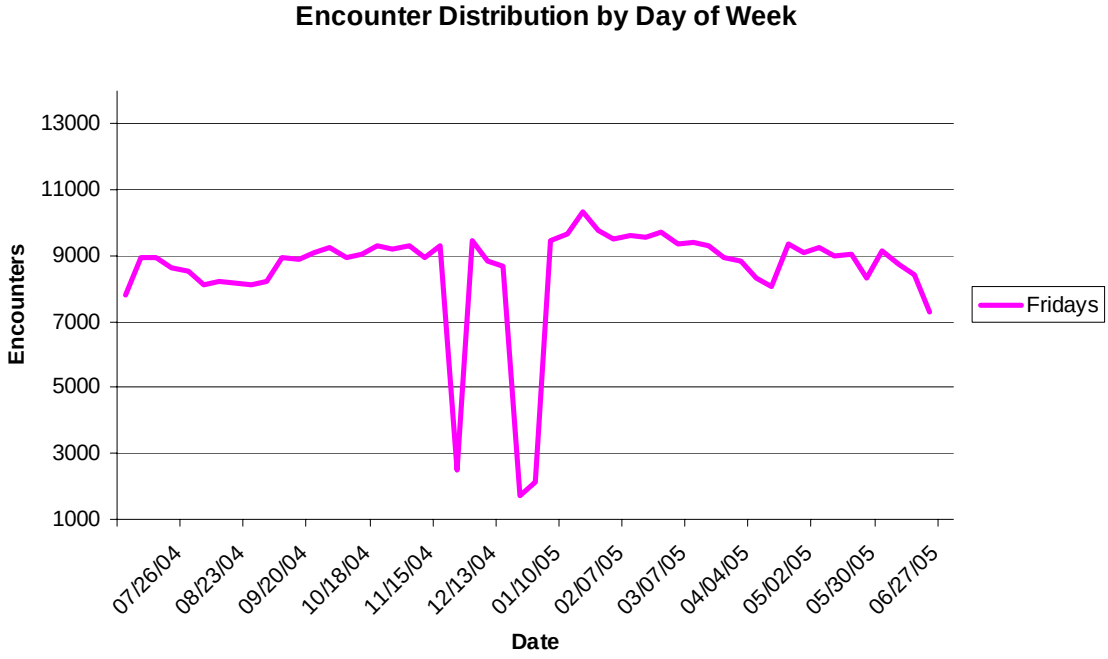
11/15/04
12/13/04
01/10/05
02/07/05
03/07/05
04/04/05
05/02/05
05/30/05
06/27/05
Date
Thursdays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Encounters
13000
11000
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7000
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1000
07/26/04
08/23/04
09/20/04
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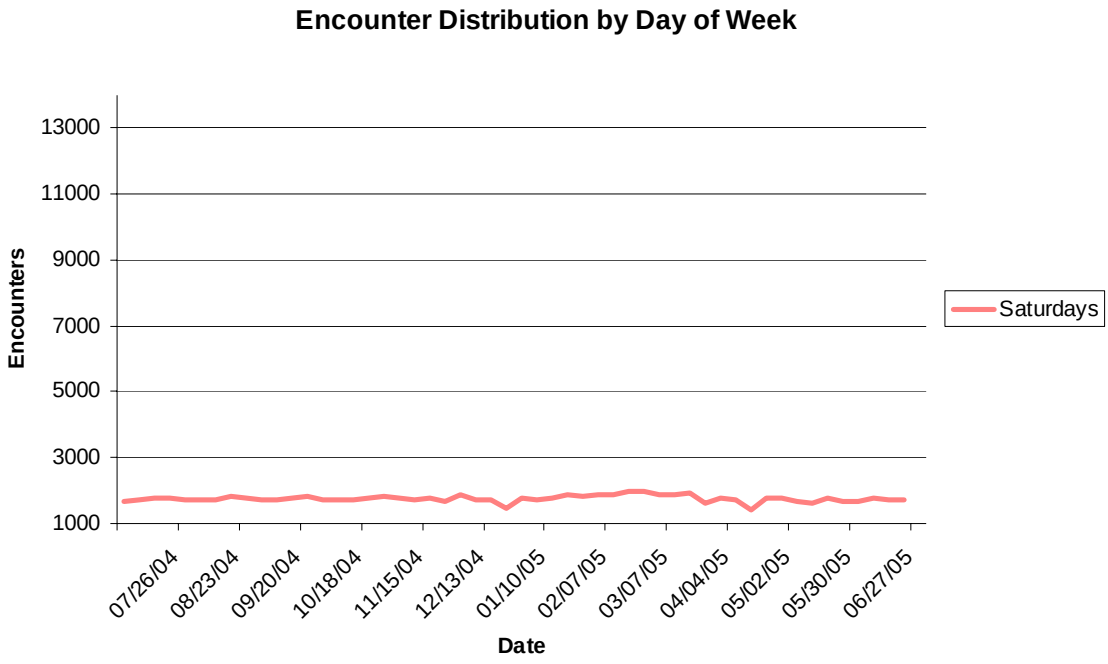
11/15/04
12/13/04
01/10/05
02/07/05
03/07/05
04/04/05
05/02/05
05/30/05
06/27/05
Date
Fridays


Encounter Distribution by Day of Week
13000
11000
9000
7000
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3000
1000
Encounters
07/26/04
08/23/04
09/20/04
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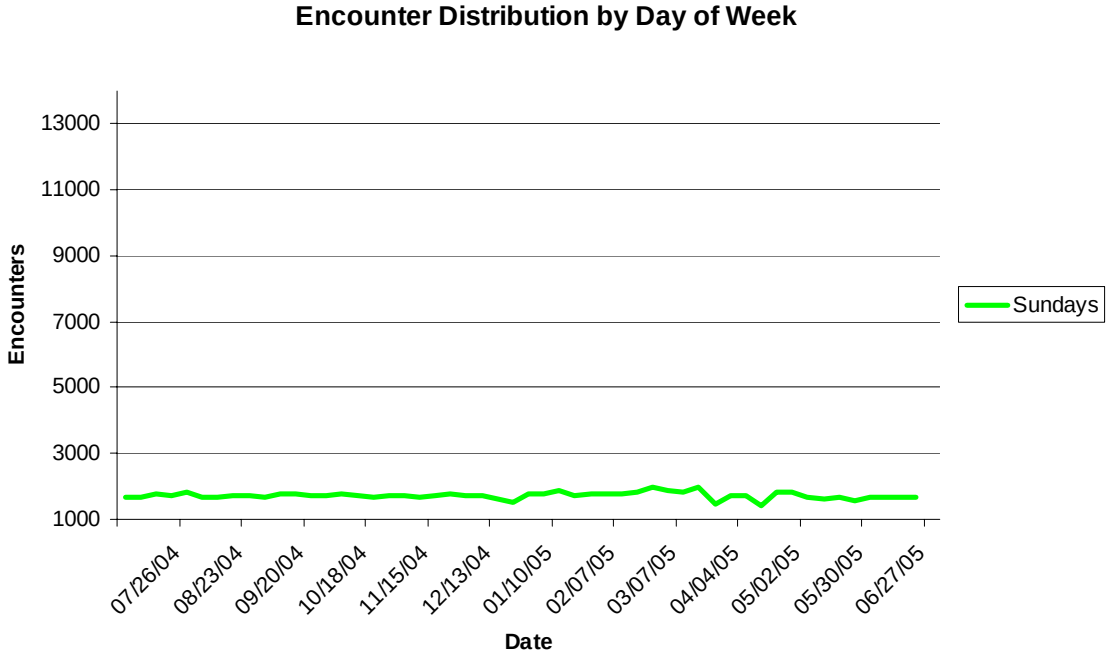
11/15/04
12/13/04
01/10/05
02/07/05
03/07/05
04/04/05
05/02/05
05/30/05
06/27/05
Date
Saturdays


Encounter Distribution by Day of Week
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3000
1000
Encounters
07/26/04
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09/20/04
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11/15/04
12/13/04
01/10/05
02/07/05
03/07/05
04/04/05
05/02/05
05/30/05
06/27/05
Date
Sundays

State Standards		2005 Encounter Validation Raw Results - Phase I														
Data Element	**Data Standard**	**Statewide**	**PIHP 410**	**PIHP 411**	**PIHP 412**	**PIHP 413**	**PIHP 414**	**PIHP 415**	**PIHP 416**	**PIHP 417**	**PIHP 418**	**PIHP 419**	**PIHP 420**	**PIHP 424**	**PIHP 425**	**PIHP 426**
Outpatient Service			SC	KC	NS	GC	NC	NE	PEN	SW	TM	PC	GH	CC	CD	TL
Reporting Unit ID *(Contractor ID or RSN ID)*	100% valid, non-missing	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Claim Submit Identifier	100% valid, non-missing	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Consumer ID	100% valid, non-missing	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
CPT or HCPC Code	99% present (not zero, blank, 8- or 9-filled). 100% should be valid, State-approved codes. There should be a wide range of procedures with the same frequency as previously encountered.	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Health Care Service Location	95% valid non-missing	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Minutes of Service	100% non-zero; 100% should be valid for the associated CPT Code when present	87.07%	78.37%	82.63%	82.92%	99.57%	99.97%	98.89%	93.78%	96.20%	92.72%	95.20%	92.29%	86.00%	87.10%	99.67%
Person Identification Code	100% valid, non-missing	97.84%	92.19%	97.62%	98.86%	99.92%	100.00%	99.61%	97.96%	99.98%	99.59%	99.45%	98.25%	99.90%	98.96%	99.07%
Provider Type	80% valid, non-missing	99.95%	100.00%	100.00%	100.00%	100.00%	97.26%	99.89%	100.00%	100.00%	100.00%	100.00%	96.67%	100.00%	100.00%	100.00%
Reporting Unit ID	99% present (not zero, blank, 8- or 9-filled). 100% should be valid	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Service Date	100% valid, non-missing; Dates should be evenly distributed across time	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
E&T Inpatient Service																
Admission Date (entry present for each episode)	100% valid, non-missing	100.00%		100.00%	100.00%				100.00%		100.00%					
Discharge Date	100% valid, non-missing	100.00%		100.00%	100.00%				100.00%		100.00%					
Admit Discharge Correspondence	100% of admits and discharges match across all episodes of E&T care	100.00%		100.00%	100.00%				100.00%		100.00%					
Consumer Demographics																
Given Name	>85% present	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Surname	>85% present	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Gender	< 2% missing or invalid	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Date of Birth	< 2% missing or invalid	99.99%	100.00%	100.00%	100.00%	100.00%	99.91%	100.00%	100.00%	100.00%	100.00%	99.95%	100.00%	100.00%	100.00%	100.00%
Race	< 2% missing or invalid	98.02%	100.00%	99.78%	99.99%	99.98%	99.73%	100.00%	75.13%	100.00%	86.86%	100.00%	100.00%	99.93%	100.00%	100.00%
Ethnicity	< 2% missing or invalid	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Hispanic Origin	< 2% missing or invalid	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Preferred Language	< 2% missing or invalid	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Social Security Number	80% present	95.01%	97.56%	98.00%	93.94%	98.54%	89.26%	56.29%	94.29%	92.15%	84.78%	92.06%	96.05%	98.34%	91.29%	87.19%

Consumer Periodics	Periodics standards apply only for those receiving non-crisis services															
Employment Status	80% valid, non-missing	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Education	80% valid, non-missing	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Grade Level	80% valid, non-missing	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Living Situation	80% valid, non-missing	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
County of Residence	< 2% missing or invalid	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Priority Code	> 90% non-missing and valid codes	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Diagnosis	> 90% non-missing and valid codes (using ICD-9-CM lookup tables)	92.52%	99.90%	99.73%	0.00%	99.81%	99.90%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Impairment Kind	> 90% non-missing and valid codes	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Annual Gross Income	80% valid, non-missing	93.71%	99.91%	98.69%	100.00%	100.00%	100.00%	68.29%	80.80%	100.00%	76.26%	71.51%	99.95%	95.55%	97.46%	99.97%
GAF	100% valid, non-missing	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
CGAS	100% valid, non-missing	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
DC03	100% valid, non-missing	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Consumer Periodics - Adjusted Completeness		Statewide	PIHP 410	PIHP 411	PIHP 412	PIHP 413	PIHP 414	PIHP 415	PIHP 416	PIHP 417	PIHP 418	PIHP 419	PIHP 420	PIHP 424	PIHP 425	PIHP 426
Employment Status	80% valid, non-missing	93.37%	91.38%	99.48%	88.17%	95.37%	96.27%	92.81%	94.23%	96.65%	93.35%	73.59%	97.58%	71.28%	97.61%	98.41%
Education	80% valid, non-missing	95.49%	90.33%	99.48%	87.75%	92.76%	94.94%	91.91%	92.55%	95.79%	94.38%	90.55%	93.13%	93.72%	93.22%	98.41%
Grade Level	80% valid, non-missing	87.80%	84.36%	94.88%	80.29%	83.72%	61.70%	40.35%	78.14%	91.08%	89.24%	78.38%	84.19%	87.90%	89.81%	94.20%
Living Situation	80% valid, non-missing	97.55%	92.07%	99.89%	91.06%	95.81%	99.16%	97.42%	95.16%	94.18%	99.70%	96.32%	98.62%	98.00%	97.19%	99.46%
County of Residence	< 2% missing or invalid	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Priority Code	> 90% non-missing and valid codes	94.49%	95.63%	99.81%	69.75%	94.45%	97.26%	78.12%	96.73%	38.87%	97.41%	93.58%	92.49%	92.17%	93.73%	88.25%
Diagnosis	> 90% non-missing and valid codes (using ICD-9-CM lookup tables)	92.52%	99.90%	99.73%	0.00%	99.81%	99.90%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Impairment Kind	> 90% non-missing and valid codes	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Annual Gross Income	80% valid, non-missing	93.71%	99.91%	98.69%	100.00%	100.00%	100.00%	68.29%	80.80%	100.00%	76.26%	71.51%	99.95%	95.55%	97.46%	99.97%
GAF	100% valid, non-missing	94.23%	89.95%	97.63%	81.50%	93.73%	97.73%	89.91%	93.67%	91.54%	97.28%	90.69%	90.88%	88.62%	81.15%	90.02%
CGAS	100% valid, non-missing	79.94%	99.64%	99.83%	95.64%	99.78%	98.46%	98.81%	99.73%	98.33%	99.21%	97.32%	100.00%	99.86%	98.52%	99.91%
DC03	100% valid, non-missing	67.94%	84.47%	93.55%	17.95%	92.28%	0.00%	77.78%	86.89%	37.78%	76.86%	0.00%	100.00%	96.49%	73.91%	97.73%

2004 Score Table with Enrollment-Weighted Statewide Averages - Subpart C

<< Shading indicates 2004 Corrective Action Item

text << Underlining indicates 2004 EQRO improvement recommendation

Item	Weighting Factor: Enrollment (1,000s)*	King	Greater Columbia	North Sound	Pierce	Spokane	Clark	Peninsula	Thurston Mason	North Central	Southwest	Timberlands	Chelan-Douglas	Northeast	Grays Harbor	WA State Simple Average	WA State Weighted Average	Strength Stars: Q(s1) Is State Wtd Average at least 3.7?	Strength Stars: Q(s2) Did more than 9 PIHPs score at least 3.7?	Strength Stars: Stars Items satis-fying both Q(s1) & Q(s2)	Weakness Flags: Q(w1) Is State Wtd Average less than 3?	Weakness Flags: Q(w2) Did more than 7 PIHPs score under 3?	Weakness Flags: Flags Items satis-fying both Q(w1) & Q(w2)
		179	124	120	101	74	52	39	35	33	18	18	18	14	14			3.7	9	0 stars	3.0	7	8 flags
Q01	Accessible written information requirements F	4	1	3	2	1	1	1	4	1	4	3	2	3	1	2.2	2.3				•	•	flag
Q02	Policy guaranteeing enrollee rights	3	2	4	3	2	4	2	3	1	2	4	3	3	3	2.8	2.8				•		
Q03	Subcontracts require advising enrollees of rigl	3	2	4	4	2	3	3	4	2	1	4	2	1	2	2.6	2.9				•		
Q04	Subcontractors publicly post rights in req lang	3	1	3	2	2	3	1	1	1	2	1	2	1	1	1.7	2.1				•	•	flag
Q05	Subcontractors assure client rights understan	2	3	4	3	1	2	2	5	0	1	2	1	3	2	2.2	2.5				•	•	flag
Q06	Subcontractors protect exercising of client rigl	5	3	3	3	3	3	1	3	3	1	3	1	3	1	2.6	3.2						
Q07	Policy re: other Federal/State law compliance	3	1	3	1	2	1	1	3	3	1	4	4	4	4	2.5	2.2				•		
Q08	Subcontracts include Federal/State law comp	4	3	3	5	5	2	2	3	4	4	3	4	4	4	3.6	3.6						
Q09	Policies ensure specific rights compliance	2	1	3	4	2	3	4	2	2	2	2	3	2	3	2.5	2.4				•	•	flag
Q10	Subcontracts reference specific rights complia	3	2	5	3	2	2	4	3	2	2	4	2	3	1	2.7	2.9				•		
Q11	PIHP monitors provider compliance with laws/	3	1	4	5	1	3	2	2	2	1	2	1	1	2	2.1	2.6				•	•	flag
Q12	PIHP P&P against prohibitions re: advising er	2	3	3	5	3	3	2	3	2	3	4	4	5	3	3.2	3.0						
Q13	Enrollee payment liability protections	1	2	2	3	0	3	2	2	2	2	3	1	3	1	1.9	1.8				•	•	flag
Q14	PIHP P&P re: Mental Health Advance Directi	2	1	4	1	1	2	2	4	1	1	4	4	2	4	2.4	2.1				•	•	flag
Q15	Prompt law upadates to MHAD P&P	2	0	4	3	2	2	3	4	2	3	4	2	2	3	2.6	2.3				•		
Q16	Subcontractors req to have MHAD P&P	3	3	4	4	3	3	2	2	3	2	4	2	4	2	2.9	3.2						
Q17	Document clients informed of MHAD & choice	2	0	4	3	1	1	1	2	3	1	4	2	0	1	1.8	1.9				•	•	flag

** as of June 2004, calculated December 2005*

2004 Score Table with Enrollment-Weighted Statewide Averages - Subpart D

shading indicates 2004 Corrective Action Item
text << Underlining indicates 2004 EQRO improvement recommendation

Item		King	Greater Columbia	North Sound	Pierce	Spokane	Clark	Peninsula	Thurston Mason	North Central	Southwest	Timberlands	Chelan-Douglas	Northeast	Grays Harbor	WA State Simple Average	WA State Weighted Average	*Strength Stars* Q(s1) Is State Wtd Average at least 3.7?	Q(s2) Did more than 9 PIHPs score at least 3.7?	Stars Items satis-fying both Q(s1) & Q(s2)	*Weakness Flags* Q(w1) Is State Wtd Average less than 3?	Q(w2) Did more than 7 PIHPs score under 3?	Flags Items satis-fying both Q(w1) & Q(w2)
	Weighting Factor: Enrollment (1,000s)*	179	124	120	101	74	52	39	35	33	18	18	18	14	14			3.7	9	0 stars	3.0	7	23 flags
Q18	PIHP monitors access and service availability	3	1	4	4	2	3	3	4	3	2	5	4	3	2	3.1	2.9				•		
Q19	PIHP monitors & reports network sufficiency c	2	3	1	3	3	4	3	4	3	0	4	3	3	3	2.8	2.6				•		
Q20	PIHP manages network adequacy	3	1	2	4	3	3	3	4	3	1	5	3	3	2	2.9	2.7				•		
Q21	Second opinion mechanism	1	3	4	3	1	3	2	2	2	2	2	2	2	2	2.2	2.3				•	•	*flag*
Q22	PIHP has out-of-network P&P	2	2	4	2	0	2	2	2	3	2	3	2	2	0	2.0	2.1				•	•	*flag*
Q23	PIHP P&P re: out-of-network payment coordir	2	1	2	2	0	2	2	2	3	2	2	3	2	1	1.9	1.7				•	•	*flag*
Q24	PIHP P&P re: out-of-network cost to enrollee	1	1	4	0	0	2	2	2	2	1	2	3	3	1	1.7	1.5				•	•	*flag*
Q25	Ensures compliance with timely access stand	4	3	4	2	2	4	4	5	4	2	3	3	4	4	3.4	3.4						
Q26	Timely access standards in subcontracts	3	3	3	2	2	4	4	5	4	3	3	3	3	4	3.3	3.0						
Q27	PIHP oversight of provider timely access com	3	3	4	2	1	3	1	5	3	1	4	4	1	2	2.6	2.8				•		
Q28	Culturally competent services by MH Specialis	5	4	2	5	3	5	4	4	3	1	5	3	4	4	3.7	3.9	•					
Q29	Written & oral translation of client materials	2	1	2	4	2	3	2	2	1	3	2	1	2	1	2.0	2.1				•	•	*flag*
Q30	Ensure Interpreter availability	3	3	4	3	2	4	2	3	3	3	3	4	1	3	2.9	3.1						
Q31	Culturally competent subcontractor specialists	5	4	3	5	3	5	4	4	3	3	3	3	4	4	3.8	4.1	•					
Q32	Written and oral translation by subcontractors	2	1	3	3	2	3	3	3	1	2	3	2	1	2	2.2	2.2				•	•	*flag*
Q33	Monitoring of culturally competent services	4	3	3	4	1	4	3	3	3	1	4	2	4	3	3.0	3.2						
Q34	Sufficiency of provider network to meet need	3	1	2	4	2	2	3	4	3	2	5	2	3	2	2.7	2.6				•		
Q35	Changes in capacity and services reported to	2	5	3	4	3	4	3	4	3	0	4	1	3	3	3.0	3.2						
Q39	Consistent authorization standards	2	2	4	2	3	2	2	2	4	1	3	3	2	2	2.4	2.5				•	•	*flag*
Q40	Authorization conducted by MHPs	1	1	4	2	4	2	3	3	0	2	3	1	3	2	2.2	2.1				•	•	*flag*
Q41	Monitoring of consistent authorization practice	3	0	4	2	0	2	2	3	2	1	3	3	2	2	2.1	2.1				•	•	*flag*
Q42	Adverse action notices meet requirements	1	1	5	2	2	1	2	1	1	1	2	1	1	1	1.6	1.8				•	•	*flag*
Q43	Standard authorization requirements	1	0	5	1	2	2	2	3	2	2	2	1	2	2	1.9	1.8				•	•	*flag*
Q44	Expedited authorization requirements	2	0	2	1	2	2	1	3	0	2	2	3	3	2	1.8	1.5				•	•	*flag*
Q45	Extension of expedited authorization request	0	0	2	0	2	2	1	2	0	2	2	3	2	2	1.4	0.9				•	•	*flag*
Q47	Protection against provider discrimination	2	0	3	0	1	2	2	3	3	3	3	3	3	4	2.3	1.7				•		
Q48	Policy re: excluded providers	3	3	4	3	2	3	4	2	3	3	5	5	3	3	3.3	3.1						
Q49	Confidentiality compliance	5	5	4	5	4	5	1	5	5	2	5	3	3	3	3.9	4.4	•					
Q50	Privacy compliance by subcontractors	5	3	4	3	3	1	3	5	5	3	5	3	3	3	3.5	3.7						
Q51	Privacy compliance subcontractor audits	5	0	4	0	2	3	0	4	1	0	3	3	2	0	1.9	2.4				•	•	*flag*
Q52	Pre-subdelegation evaluation	5	1	2	1	3	3	1	2	1	0	2	2	1	1	1.8	2.4				•	•	*flag*
Q53	Written subdelegation agreement	5	1	3	0	4	4	1	1	1	1	1	2	1	1	1.9	2.5				•	•	*flag*
Q54	Annual subcontractor subdelegation performa	5	1	3	2	1	4	1	1	1	0	2	2	1	2	1.9	2.5				•	•	*flag*
Q55	Corrective actions re: subdelegation deficienc	5	1	5	1	1	4	2	2	2	0	2	2	1	2	2.1	2.8				•	•	*flag*
Q56	Adoption of evidenced based practice guidelir	1	1	3	1	0	1	2	3	0	1	5	2	2	2	1.7	1.4				•	•	*flag*
Q57	Dissemination of practice guidelines	1	1	3	2	1	2	3	3	1	0	4	2	2	2	1.9	1.7				•	•	*flag*
Q58	Application of practice guidelines	0	0	2	1	1	0	2	1	0	0	2	1	1	2	0.9	0.7				•	•	*flag*
Q60	Performance measurement data submission	2	3	2	2	2	3	2	2	3	3	4	4	2	2	2.6	2.4				•	•	*flag*
Q61	Detection of over & under utilization	3	4	5	2	3	3	2	2	1	1	3	3	1	2	2.5	3.1						
Q62	Quality care to enrollees with special health n	4	4	4	2	3	5	4	3	3	0	2	2	3	2	2.9	3.4						
Q63	Annual performance report to State																	X	X	*X*	X	X	*X*
Q64	Annual data submission to State	2	4	3	2	2	2	2	2	2	1	5	3	3	2	2.5	2.5				•	•	*flag*
Q65	Combined activities option																	X	X	*X*	X	X	*X*

** as of June 2004, calculated December 2005*

2004 Score Table with Enrollment-Weighted Statewide Averages - Subpart F

<< Shading indicates 2004 Corrective Action Item
text << Underlining indicates 2004 EQRO improvement recommendation

Item		King	Greater Columbia	North Sound	Pierce	Spokane	Clark	Peninsula	Thurston Mason	North Central	Southwest	Timberlands	Chelan-Douglas	Northeast	Grays Harbor	WA State Simple Average	WA State Weighted Average	*Strength Stars* Q(s1) Is State Wtd Average at least 3.7?	Q(s2) Did more than 9 PIHPs score at least 3.7?	Stars Items satis-fying both Q(s1) & Q(s2)	*Weakness Flags* Q(w1) Is State Wtd Average less than 3?	Q(w2) Did more than 7 PIHPs score under 3?	Flags Items satis-fying both Q(w1) & Q(w2)
	Weighting Factor: Enrollment (1,000s)*	**179**	**124**	**120**	**101**	**74**	**52**	**39**	**35**	**33**	**18**	**18**	**18**	**14**	**14**			**3.7**	**9**	**0 stars**	**3.0**	**7**	**16 flags**
Q71	Authority to file grievance	2	3	4	2	2	2	2	2	2	1	3	5	3	2	**2.5**	**2.5**				•	•	***flag***
Q72	Timing and Procedures for filing	3	1	3	4	2	2	2	1	2	1	3	3	3	0	**2.1**	**2.4**				•	•	***flag***
Q73	Timing of notice	1	1	3	2	1	1	2	1	1	1	2	2	1	1	**1.4**	**1.5**				•	•	***flag***
Q74	Administrative assitance for enrollees	2	4	4	3	1	3	2	3	2	1	3	3	3	2	**2.6**	**2.8**				•		
Q75	Grievance acknowledgement	3	2	3	3	2	2	2	3	2	2	3	1	3	2	**2.4**	**2.5**				•	•	***flag***
Q76	Appropriate grievance review personnel	3	3	3	3	2	3	2	3	2	2	3	2	3	2	**2.6**	**2.8**				•		
Q77	Special requirements for appeals	1	2	5	3	2	2	2	3	2	2	3	2	3	2	**2.4**	**2.4**				•	•	***flag***
Q78	Enrollee access to case file	2	1	3	3	2	2	2	3	2	2	3	2	3	2	**2.3**	**2.2**				•	•	***flag***
Q79	Included appeal parties	3	0	3	3	2	2	2	0	2	2	3	2	3	2	**2.1**	**2.1**				•	•	***flag***
Q80	Resolution and notification of grievances & ap	3	2	2	3	2	2	2	3	2	2	3	2	3	2	**2.4**	**2.4**				•	•	***flag***
Q81	Content of Notice of Appeal Resolution	3	2	4	3	2	2	2	3	2	2	3	2	3	2	**2.5**	**2.7**				•	•	***flag***
Q82	State fair hearings requirements	3	1	4	3	2	2	2	2	2	2	3	2	2	1	**2.2**	**2.5**				•	•	***flag***
Q83	Expedied appeal resolution/prohibition agains	2	2	3	3	2	2	2	3	2	2	3	2	3	2	**2.4**	**2.3**				•	•	***flag***
Q84	Denial of expedited resolution	3	2	3	3	1	2	2	3	2	2	3	2	3	2	**2.4**	**2.5**				•	•	***flag***
Q85	Use of State developed description in subcon	2	3	4	3	3	3	2	3	2	3	3	1	3	3	**2.7**	**2.8**				•		
Q86	Record keeping	2	4	4	3	2	2	2	3	2	2	1	3	2	1	**2.4**	**2.7**				•	•	***flag***
Q87	Review and quality improvement	2	4	4	3	2	3	2	3	2	2	2	2	1	3	**2.5**	**2.8**				•	•	***flag***
Q88	Rights upheld during pended appeal	2	2	2	3	2	2	2	3	1	1	3	2	3	1	**2.1**	**2.1**				•	•	***flag***
Q89	Rights upheld regarding disputed services	3	2	2	3	0	2	2	3	2	2	3	2	3	3	**2.3**	**2.3**				•	•	***flag***

** as of June 2004, calculated December 2005*

2004 Score Table with Enrollment-Weighted Statewide Averages - Subpart H

			<< Shading indicates 2004 Corrective Action Item															*Strength Stars*			*Weakness Flags*		
			text << Underlining indicates 2004 EQRO improvement recommendation															Q(s1)	Q(s2)	Stars	Q(w1)	Q(w2)	Flags
		King	Greater Columbia	North Sound	Pierce	Spokane	Clark	Peninsula	Thurston Mason	North Central	Southwest	Timberlands	Chelan-Douglas	Northeast	Grays Harbor	WA State Simple Average	WA State Weighted Average	Is State Wtd Average at least 3?	Did more than 9 PIHPs score at least 3?	Items satis-fying both Q(s1) & Q(s2)	Is State Wtd Average less than 3?	Did more than 7 PIHPs score under 3?	Items satis-fying both Q(w1) & Q(w2)
Item	Weighting Factor: Enrollment (1,000s)*	**179**	**124**	**120**	**101**	**74**	**52**	**39**	**35**	**33**	**18**	**18**	**18**	**14**	**14**			**3.0**	**9**	**2 stars**	**3.0**	**7**	**1 flags**
Q90.a	Source of certification	3	3	0	3	3	3	3	3	3	0	3	0	3	3	**2.4**	**2.4**		•		•		
Q90.b1	Data content certification	3	3	0	3	3	3	3	3	3	0	3	0	3	3	**2.4**	**2.4**		•		•		
Q90.b2	Certification content requirements	3	3	0	3	3	3	3	3	3	0	3	0	3	3	**2.4**	**2.4**		•		•		
Q90.b3	Certification timing	0	3	0	3	0	3	0	3	3	0	3	0	3	0	**1.5**	**1.4**				•		
Q91.b1	Written fraud & abuse p&ps/compliance plan	3	3	3	3	3	3	3	3	3	3	3	3	3	3	**3.0**	**3.0**	•	•	***star***			
Q91.b2	Accountable compliance officer/committee	3	3	3	3	3	3	3	3	3	3	3	3	3	3	**3.0**	**3.0**	•	•	***star***			
Q91.b3	Effective Compliance training and education	3	3	3	3	3	3	3	3	3	0	3	3	3	0	**2.6**	**2.9**		•		•		
Q91.b4	Effective compliance communication	3	3	0	0	0	3	3	0	3	3	3	0	3	3	**1.9**	**1.8**				•		
Q91.b5	Well publicized disciplinary guidelines	3	3	3	3	3	0	3	3	0	3	3	3	3	3	**2.6**	**2.7**		•		•		
Q91.b6	Internal audit provisions	0	0	3	0	0	0	0	0	0	0	0	0	0	0	**0.2**	**0.4**				•	•	***flag***
Q91.b7	Prompt response to offenses	3	3	3	3	0	3	3	3	3	0	3	3	3	0	**2.6**	**2.7**		•		•		
Q92	Prohibited affiliations with the Federally debar	3	3	3	0	3	3	3	3	0	3	3	3	3	3	**2.6**	**2.5**		•		•		

** as of June 2004, calculated December 2005*

Data Element	Standards for Validation of Data Elements Description	Data Standard	Encounter Phase[1]
Outpatient Service			
Reporting Unit ID *(Contractor ID or RSN ID)*	For example, 419 for Pierce, 416 for Peninsula, etc	100% valid, non-missing	**I & II**
Claim Submit Identifier	Uniquely identifies an individual service within an RSN.	100% valid, non-missing	**I**
Consumer ID	Uniquely identifies a consumer within an RSN.	100% valid, non-missing	**I & II**
CPT or HCPC Code	Procedure or service code	99% present (not zero, blank, 8- or 9-filled). 100% should be valid, State-approved codes. There should be a wide range of procedures with the same frequency as previously encountered.	**I & II**
Health Care Service Location	Identified where a service was provided.	95% valid non-missing	**I**
Minutes of Service	The number of minutes a specific service was provided	100% non-zero; 100% should be valid for the associated CPT Code when present	**I & II**
Person Identification Code	ACES/MAA provided pic_code	100% valid, non-missing	**I**
Provider Type	Identifies the professional level of a specific outpatient service provider	80% valid, non-missing	**I**
Reporting Unit ID	Subcontractor or agency that provided service	99% present (not zero, blank, 8- or 9-filled). 100% should be valid	**I & II**
Service Date	Date a service was provided.	100% valid, non-missing; Dates should be evenly distributed across time	**I & II**
E&T Inpatient Service	Replaced as appropriate by HIPAA Compliant 837I. – MHD extracts data from the 837I and executes this transaction to maintain current MHD SQL tables.		
Admission Date (entry present for each episode)	Date a person was admitted to a facility. Entry present for each episode. Client may have multiple episodes.	100% valid, non-missing	**I**
Discharge Date	Date a person was released from a facility. Entry present for each episode. Client may have multiple episodes	100% valid, non-missing	**I**
Admit Discharge Correspondence	Should be a One-to-0ne correspondence between each admit and discharge episode	100% of admits and discharges match across all episodes of E&T care	**I**

Data Element	Standards for Validation of Data Elements Description	Data Standard	Encounter Phase[1]
Consumer Demographics			
Given Name	First Name	>85% present	I
Surname	Last Name	>85% present	I
Gender		< 2% missing or invalid	I
Date of Birth		< 2% missing or invalid	I
Race	Code indicating the racial or ethnic background of a consumer	< 2% missing or invalid	I
Ethnicity	Taken from the Year 2000 census survey form as published by the Bureau of Census. Select one or more races to indicate what this person considers himself/herself to be.	< 2% missing or invalid	I
Hispanic Origin		< 2% missing or invalid	I
Preferred Language	This code identifies the language in which a person prefers to receive services.	< 2% missing or invalid	I
Social Security Number		80% present	I
Consumer Periodics[2]		Periodics standards apply only for those receiving non-crisis services	
Employment Status	Employment status of the consumer	80% valid, non-missing	I
Education	Describes if a consumer is in a formal educational program	80% valid, non-missing	I
Grade Level	Identifies the highest-grade level completed by the consumer.	80% valid, non-missing	I
Living Situation	Identifies the environment in which the client lives.	80% valid, non-missing	I
County of Residence	A code indicating the county where a person lives	< 2% missing or invalid	I
Priority Code	An indicator of the relative seriousness duration and intensity of the presenting mental disorder of a particular person as well as distinguishing whether the consumer is a member of a targeted group as established by legislative mandate.	> 90% non-missing and valid codes	I
Diagnosis	Four occurrences - use ICD9 format	> 90% non-missing and valid codes (using ICD-9-CM lookup tables)	I
Impairment Kind	The set of codes that identifies an individual's disability	> 90% non-missing and valid codes	I
Annual Gross Income	Average annual family income. Family defined as members who normally share living environment who share income.	80% valid, non-missing	I
GAF[2]	Global Assessment of Functioning	100% valid, non-missing	I
CGAS[2]	Children Global Assessment Scale	100% valid, non-missing	I
DC03[2]	Assessment for Children 5 years of age or younger	100% valid, non-missing	I

[1]Phase I consists of comparing administrative data sets to the standards in Column 3. Phase II consists of comparison of administrative data sets to data in consumers clinical record(s)

[2]Some variables would be expected to change over time. The criteria for how often these variables should change has not been determined. It could be set as "not zero", 50% , or some other value. Different variables in this subset may warrant different criteria.

State Standards	2005 Encounter Validation Raw Results - Phase II															
Data Element	**A-Statewide**	**A-Side 410**	**A-Side 411**	**A-Side 412**	**A-Side 413**	**A-Side 414**	**A-Side 415**	**A-Side 416**	**A-Side 417**	**A-Side 418**	**A-Side 419**	**A-Side 420**	**A-Side 424**	**A-Side 425**	**A-Side 426**	**B-Statewide**
Outpatient Service	A-ALL	SC	KC	NS	GC	NC	NE	PEN	SW	TM	PC	GH	CC	CD	TL	B-side
Reporting Unit ID *(Contractor ID or RSN ID)*	22.55%	0.00%	0.00%	0.00%	0.00%	0.00%	62.50%	87.50%	51.11%	60.00%	0.00%	0.00%	0.00%	37.50%	0.00%	18.94%
Consumer ID	63.40%	82.76%	100.00%	96.67%	96.67%	55.17%	63.33%	100.00%	93.33%	20.00%	86.67%	0.00%	93.33%	0.00%	0.00%	24.80%
CPT or HCPC Code	51.83%	30.61%	75.45%	26.04%	95.71%	72.07%	88.32%	95.58%	89.15%	0.00%	67.20%	0.39%	75.26%	93.70%	0.12%	56.42%
Minutes of Service	81.34%	87.76%	79.83%	42.78%	99.28%	72.07%	88.32%	95.58%	89.15%	95.13%	67.35%	97.67%	77.35%	99.39%	85.62%	69.98%
Reporting Unit ID (Provider Agency or Sul	39.34%	14.29%	0.00%	19.05%	40.54%	0.00%	90.00%	100.00%	55.56%	74.36%	92.11%	0.00%	0.00%	58.06%	3.33%	8.33%
Service Date	81.34%	87.76%	79.83%	42.78%	99.28%	72.07%	88.32%	95.58%	89.15%	95.13%	67.35%	97.67%	77.35%	99.39%	85.62%	69.98%
Encounter Matches	81.34%	87.76%	79.83%	42.78%	99.28%	72.07%	88.32%	95.58%	89.15%	95.13%	67.35%	97.67%	77.35%	99.39%	85.62%	69.98%

	Statewide	**B-Side 410**	**B-Side 411**	**B-Side 412**	**B-Side 413**	**B-Side 414**	**B-Side 415**	**B-Side 416**	**B-Side 417**	**B-Side 418**	**B-Side 419**	**B-Side 420**	**B-Side 424**	**B-Side 425**	**B-Side 426**	**B-Statewide**
	ALL	SC	KC	NS	GC	NC	NE	PEN	SW	TM	PC	GH	CC	CD	TL	B-ALL
Encounter Matches		66.58%	81.08%	92.24%	76.85%	30.00%	96.67%	48.33%	80.64%	54.92%	78.34%	46.69%	65.90%	88.25%	82.05%	69.98%
Average Matches (A & B)	75.66%															

2005 Score Distribution acoss PIHPs - Subpart C

Item	Short Description	Score: 0	1	2	3	4	5	Distribution: 0s	1s	2s	3s	4s	5s	3, 4 or 5
Q01	Accessible written information requirements P&	0	3	1	4	6	0	0%	21%	7%	29%	43%	0%	**71%**
Q02	Policy guaranteeing enrollee rights	0	0	2	7	5	0	0%	0%	14%	50%	36%	0%	**86%**
Q03	Subcontracts require advising enrollees of rights	0	0	2	4	8	0	0%	0%	14%	29%	57%	0%	**86%**
Q04	Subcontractors publicly post rights in req langua	0	2	3	6	2	1	0%	14%	21%	43%	14%	7%	**64%**
Q05	Subcontractors assure client rights understandi	0	1	0	6	6	1	0%	7%	0%	43%	43%	7%	**93%**
Q06	Subcontractors protect exercising of client rights	0	1	0	10	2	1	0%	7%	0%	71%	14%	7%	**93%**
Q07	Policy re: other Federal/State law compliance	0	2	1	6	5	0	0%	14%	7%	43%	36%	0%	**79%**
Q08	Subcontracts include Federal/State law complia	0	0	1	5	6	2	0%	0%	7%	36%	43%	14%	**93%**
Q09	Policies ensure specific rights compliance	0	1	3	8	2	0	0%	7%	21%	57%	14%	0%	**71%**
Q10	Subcontracts reference specific rights complian	0	0	3	7	3	1	0%	0%	21%	50%	21%	7%	**79%**
Q11	PIHP monitors provider compliance with laws/ri	0	3	3	5	2	1	0%	21%	21%	36%	14%	7%	**57%**
Q12	PIHP P&P against prohibitions re: advising enrc	0	0	0	7	5	2	0%	0%	0%	50%	36%	14%	**100%**
Q13	Enrollee payment liability protections	1	1	2	8	2	0	7%	7%	14%	57%	14%	0%	**71%**
Q14	PIHP P&P re: Mental Health Advance Directive	0	2	3	1	8	0	0%	14%	21%	7%	57%	0%	**64%**
Q15	Prompt law upadates to MHAD P&P	0	0	1	7	6	0	0%	0%	7%	50%	43%	0%	**93%**
Q16	Subcontractors req to have MHAD P&P	0	0	0	7	7	0	0%	0%	0%	50%	50%	0%	**100%**
Q17	Document clients informed of MHAD & choice	0	2	3	5	4	0	0%	14%	21%	36%	29%	0%	**64%**
	All Scores of 0 through 5:	**1**	**18**	**28**	**103**	**79**	**9**	**0%**	**8%**	**12%**	**43%**	**33%**	**4%**	**80%**

	<< **Shading** indicates 2004 Corrective Action Item
text	<< **Underlining** indicates 2004 EQRO improvement recommendation

2005 Score Distribution acoss PIHPs - Subpart D

Item	Short Description	Score: 0	1	2	3	4	5	Distribution: 0	1	2	3	4	5	3, 4 or 5
Q18	PIHP monitors access and service availability	0	0	2	7	4	1	0%	0%	14%	50%	29%	7%	**86%**
Q19	PIHP monitors & reports network sufficiency cha	0	0	0	11	3	0	0%	0%	0%	79%	21%	0%	**100%**
Q20	PIHP manages network adequacy	0	1	1	9	2	1	0%	7%	7%	64%	14%	7%	**86%**
Q21	Second opinion mechanism	0	0	4	7	2	1	0%	0%	29%	50%	14%	7%	**71%**
Q22	PIHP has out-of-network P&P	0	1	3	9	1	0	0%	7%	21%	64%	7%	0%	**71%**
Q23	PIHP P&P re: out-of-network payment coordinat	0	1	4	7	2	0	0%	7%	29%	50%	14%	0%	**64%**
Q24	PIHP P&P re: out-of-network cost to enrollee	1	1	5	4	3	0	7%	7%	36%	29%	21%	0%	**50%**
Q25	Ensures compliance with timely access standar	0	0	0	4	9	1	0%	0%	0%	29%	64%	7%	**100%**
Q26	Timely access standards in subcontracts	0	0	1	7	5	1	0%	0%	7%	50%	36%	7%	**93%**
Q27	PIHP oversight of provider timely access compli	0	1	1	6	5	1	0%	7%	7%	43%	36%	7%	**86%**
Q28	Culturally competent services by MH Specialists	0	0	1	3	6	4	0%	0%	7%	21%	43%	29%	**93%**
Q29	Written & oral translation of client materials	0	3	5	4	2	0	0%	21%	36%	29%	14%	0%	**43%**
Q30	Ensure Interpreter availability	0	0	2	8	4	0	0%	0%	14%	57%	29%	0%	**86%**
Q31	Culturally competent subcontractor specialists	0	0	0	6	5	3	0%	0%	0%	43%	36%	21%	**100%**
Q32	Written and oral translation by subcontractors	0	1	6	7	0	0	0%	7%	43%	50%	0%	0%	**50%**
Q33	Monitoring of culturally competent services	0	1	2	6	5	0	0%	7%	14%	43%	36%	0%	**79%**
Q34	Sufficiency of provider network to meet need	0	0	4	7	2	1	0%	0%	29%	50%	14%	7%	**71%**
Q35	Changes in capacity and services reported to S	0	1	0	8	4	1	0%	7%	0%	57%	29%	7%	**93%**
Q39	Consistent authorization standards	0	0	3	6	5	0	0%	0%	21%	43%	36%	0%	**79%**
Q40	Authorization conducted by MHPs	0	3	2	6	3	0	0%	21%	14%	43%	21%	0%	**64%**
Q41	Monitoring of consistent authorization practices	1	1	4	5	3	0	7%	7%	29%	36%	21%	0%	**57%**
Q42	Adverse action notices meet requirements	0	7	4	1	1	1	0%	50%	29%	7%	7%	7%	**21%**
Q43	Standard authorization requirements	0	3	6	2	2	1	0%	21%	43%	14%	14%	7%	**36%**
Q44	Expedited authorization requirements	0	2	7	4	1	0	0%	14%	50%	29%	7%	0%	**36%**
Q45	Extension of expedited authorization request	1	3	6	4	0	0	7%	21%	43%	29%	0%	0%	**29%**
Q47	Protection against provider discrimination	1	0	3	8	1	1	7%	0%	21%	57%	7%	7%	**71%**
Q48	Policy re: excluded providers	0	0	1	8	3	2	0%	0%	7%	57%	21%	14%	**93%**
Q49	Confidentiality compliance	0	0	1	4	2	7	0%	0%	7%	29%	14%	50%	**93%**
Q50	Privacy compliance by subcontractors	0	0	1	8	1	4	0%	0%	7%	57%	7%	29%	**93%**
Q51	Privacy compliance subcontractor audits	2	2	2	5	2	1	14%	14%	14%	36%	14%	7%	**57%**
Q52	Pre-subdelegation evaluation	0	4	7	2	0	1	0%	29%	50%	14%	0%	7%	**21%**
Q53	Written subdelegation agreement	0	8	2	1	2	1	0%	57%	14%	7%	14%	7%	**29%**
Q54	Annual subcontractor subdelegation performanc	0	5	5	2	1	1	0%	36%	36%	14%	7%	7%	**29%**
Q55	Corrective actions re: subdelegation deficiencie	0	2	8	1	1	2	0%	14%	57%	7%	7%	14%	**29%**
Q56	Adoption of evidenced based practice guideline	0	5	4	3	1	1	0%	36%	29%	21%	7%	7%	**36%**
Q57	Dissemination of practice guidelines	1	3	2	6	2	0	7%	21%	14%	43%	14%	0%	**57%**
Q58	Application of practice guidelines	2	6	2	3	1	0	14%	43%	14%	21%	7%	0%	**29%**
Q60	Performance measurement data submission	9	0	0	2	1	2	64%	0%	0%	14%	7%	14%	**36%**
Q61	Detection of over & under utilization	0	2	4	5	2	1	0%	14%	29%	36%	14%	7%	**57%**
Q62	Quality care to enrollees with special health nee	0	1	4	4	4	1	0%	7%	29%	29%	29%	7%	**64%**
Q64	Annual data submission to State	9	0	0	2	1	2	64%	0%	0%	14%	7%	14%	**36%**
	All Scores of 0 through 5:	**27**	**68**	**119**	**212**	**104**	**44**	**5%**	**12%**	**21%**	**37%**	**18%**	**8%**	**63%**

<< **Shading** indicates 2004 Corrective Action Item

text << **Underlining** indicates 2004 EQRO improvement recommendation

2005 Score Distribution acoss PIHPs - Subpart F

		Score:						Distribution:						
Item	**Short Description**	**0**	**1**	**2**	**3**	**4**	**5**	**0**	**1**	**2**	**3**	**4**	**5**	**3, 4 or 5**
Q71	Authority to file grievance	0	0	5	3	5	1	0%	0%	36%	21%	36%	7%	**64%**
Q72	Timing and Procedures for filing	0	1	3	9	1	0	0%	7%	21%	64%	7%	0%	**71%**
Q73	Timing of notice	0	6	4	3	1	0	0%	43%	29%	21%	7%	0%	**29%**
Q74	Administrative assitance for enrollees	0	1	4	7	2	0	0%	7%	29%	50%	14%	0%	**64%**
Q75	Grievance acknowledgement	0	1	1	12	0	0	0%	7%	7%	86%	0%	0%	**86%**
Q76	Appropriate grievance review personnel	0	0	2	12	0	0	0%	0%	14%	86%	0%	0%	**86%**
Q77	Special requirements for appeals	0	1	3	9	0	1	0%	7%	21%	64%	0%	7%	**71%**
Q78	Enrollee access to case file	0	0	3	9	2	0	0%	0%	21%	64%	14%	0%	**79%**
Q79	Included appeal parties	0	0	4	10	0	0	0%	0%	29%	71%	0%	0%	**71%**
Q80	Resolution and notification of grievances & appe	0	0	4	9	1	0	0%	0%	29%	64%	7%	0%	**71%**
Q81	Content of Notice of Appeal Resolution	0	0	1	10	3	0	0%	0%	7%	71%	21%	0%	**93%**
Q82	State fair hearings requirements	0	0	6	7	1	0	0%	0%	43%	50%	7%	0%	**57%**
Q83	Expedied appeal resolution/prohibition against p	0	0	3	11	0	0	0%	0%	21%	79%	0%	0%	**79%**
Q84	Denial of expedited resolution	0	0	2	12	0	0	0%	0%	14%	86%	0%	0%	**86%**
Q85	Use of State developed description in subcontra	0	1	1	11	1	0	0%	7%	7%	79%	7%	0%	**86%**
Q86	Record keeping	0	1	4	7	2	0	0%	7%	29%	50%	14%	0%	**64%**
Q87	Review and quality improvement	0	0	3	7	4	0	0%	0%	21%	50%	29%	0%	**79%**
Q88	Rights upheld during pended appeal	0	2	1	9	2	0	0%	14%	7%	64%	14%	0%	**79%**
Q89	Rights upheld regarding disputed services	0	0	0	12	2	0	0%	0%	0%	86%	14%	0%	**100%**
	All Scores of 0 through 5:	**0**	**14**	**54**	**169**	**27**	**2**	**0%**	**5%**	**20%**	**64%**	**10%**	**1%**	**74%**

<< **Shading** indicates 2004 Corrective Action Item

text << **Underlining** indicates 2004 EQRO improvement recommendation

2005 Score Distribution acoss PIHPs - Subpart H

		Score:						Distribution:						
Item	**Short Description**	**0**	**1**	**2**	**3**	**4**	**5**	**0**	**1**	**2**	**3**	**4**	**5**	**3, 4 or 5**
Q90.a	Source of certification	2	0	0	12	0	0	14%	0%	0%	86%	0%	0%	**86%**
Q90.b1	Data content certification	1	0	0	13	0	0	7%	0%	0%	93%	0%	0%	**93%**
Q90.b2	Certification content requirements	1	0	0	13	0	0	7%	0%	0%	93%	0%	0%	**93%**
Q90.b3	Certification timing	4	0	0	10	0	0	29%	0%	0%	71%	0%	0%	**71%**
Q91.b1	Written fraud & abuse p&ps/compliance plan	0	0	0	14	0	0	0%	0%	0%	100%	0%	0%	**100%**
Q91.b2	Accountable compliance officer/committee	0	0	0	14	0	0	0%	0%	0%	100%	0%	0%	**100%**
Q91.b3	Effective Compliance training and education	1	0	0	13	0	0	7%	0%	0%	93%	0%	0%	**93%**
Q91.b4	Effective compliance communication	3	0	0	11	0	0	21%	0%	0%	79%	0%	0%	**79%**
Q91.b5	Well publicized disciplinary guidelines	1	0	0	13	0	0	7%	0%	0%	93%	0%	0%	**93%**
Q91.b6	Internal audit provisions	8	0	0	6	0	0	57%	0%	0%	43%	0%	0%	**43%**
Q91.b7	Prompt response to offenses	0	0	0	14	0	0	0%	0%	0%	100%	0%	0%	**100%**
Q92	Prohibited affiliations with the Federally debarre	1	0	0	13	0	0	7%	0%	0%	93%	0%	0%	**93%**
	All Scores of 0 through 5:	**22**	**0**	**0**	**146**	**0**	**0**	**13%**	**0%**	**0%**	**87%**	**0%**	**0%**	**87%**

<< **Shading** indicates 2004 Corrective Action Item

text << **Underlining** indicates 2004 EQRO improvement recommendation